DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration
Center for Mental Health Services

Guidance for Applicants (GFA) No. SM-02-007
Part I - Programmatic Guidance

Cooperative Agreement for Collaborative Community Actions to Prevent Youth Violence and Promote Youth Development

Short Title: Youth Violence Prevention Cooperative Agreements

Application Due Date: June 19, 2002

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Table of Contents

Agency

Department of Health and Human Services (DHHS), Substance Abuse and Mental Health Services Administration.

Action and Purpose

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS), announces the availability of fiscal year 2002 funds for cooperative agreements for implementing Youth Violence Prevention Cooperative Agreements. Awards will be made for two types of youth violence prevention projects: (1) **Youth Violence Prevention for Vulnerable Youth (Vulnerable Youth) Projects**, and (2) **School-based Mental Health (School-based) Projects**.

The **Vulnerable Youth** program supports projects developing youth violence prevention community collaborations and prevention and intervention services for youth populations vulnerable to violence and harassment, due to physical and social characteristics that differentiate them from the majority of youth. Domestic public and private nonprofit organizations are eligible to apply for Vulnerable Youth awards.

The **School-based Mental Health** program supports projects that expand or enhance school-based mental health services to promote positive mental health of students. School-based Mental Health Project applicants are restricted to public and private schools and school systems.

Approximately $2.8 million will be available for 12 to 16 awards. It is expected that six to eight Vulnerable Youth awards will be made, and six to eight School-based awards will be made. The maximum award for Vulnerable Youth Projects is $150,000 per year in total costs (direct and indirect). The maximum award for School-based Projects is $200,000 in total costs (direct and indirect). Actual funding levels will depend on the availability of funds.

Projects will be supported for up to 2 years. The second year of support depends on the availability of funds and progress achieved.

Overall Program Overview

The Youth Violence Prevention Cooperative Agreement (YVPCA) grant program supports 2-year cooperative agreements for collaborations of community organizations and constituencies to promote the prevention of youth violence, substance abuse, suicide, and other mental health and behavior problems through a public mental health approach. Through fiscal year 2001, approximately 100 YVPCA grants have been funded in communities throughout the country.

Youth violence prevention community collaborations should include or seek to recruit the significant organizations or constituencies in the target community involved with youth at risk for violence perpetration or victimization.

Projects engage in activities that include (1) building community-wide understanding of the nature, extent, and effects of violence and other negative behaviors among youth in the community; (2) mobilizing the community to address youth problems; (3) implementing and evaluating a wide range of effective intervention services to address youth problems in the community and to enhance personal and interpersonal strengths, prosocial development and positive mental health in youth; and (4) being responsive to the ethnic, cultural, social, age, gender, and sexual orientation diversity in the community, in all phases of collaborative activity, service implementation, and service provision.

This Guidance for Applicants (GFA) announcement supports two groups of youth violence prevention projects: Vulnerable Youth projects that focus on a population of youth at high risk for violence and victimization, due to social and physical vulnerabilities, and School-based projects that focus on delivery of mental health services to youth in schools.

Section I of this announcement, which begins on page 6, describes project requirement for the Youth Violence Prevention for Vulnerable Youth program. Section II, which begins on page 24, describes requirements for the School-based Mental Health program.

Section I: Vulnerable Youth Project Requirements

Program Overview

Among youth at risk for violent victimization, some youth share characteristics or life experiences which make them especially vulnerable to hostility and violent victimization, due to differences from the majority of the population. Such groups may have limited personal and social resources to be assertive and to protect themselves from violence because of prior experiences, the impact of stigmatization, or failure to be protected by responsible adults. Hence, they may experience significant prejudice, discrimination, harassment, bullying, and other forms of victimization because of their physical or social differences. There may be few dedicated service programs for these groups and a failure to address the impact of harassment and violent victimization by those that do provide services. There may be a lack of knowledge of or reluctance to access existing youth services by vulnerable youth. These high-risk and underserved groups should be a priority for community approaches to youth violence prevention, and a group of these projects will be supported by the Youth Violence Prevention for Vulnerable Youth program.

These vulnerable youth are:

- Youth with physical disabilities or developmental limitations.
- Gay, lesbian, bisexual, and transgender youth.
- Youth in out-of-home residence, such as homeless youth, runaway and thrownaway youth, and youth in foster care or residential institutions.
- Youth with parentage from more than one racial group.
- Recent immigrant and refugee youth, especially of limited English proficiency and/or of Middle Eastern background.
- Religious minority groups, especially of the Islamic faith.

Youth Violence Prevention for Vulnerable Youth projects must target one of these youth populations identified above. They must devote the initial grant period, usually at least the first year of the grant, to activities that lead to development of an effective collaboration of community organizations and constituencies to address victimization of the vulnerable youth population.

After an effective collaboration has been established, grant resources can be used to implement a set of activities and programs, on a pilot basis, that addresses violence and other types of victimization experienced by the targeted vulnerable youth population. Vulnerable Youth Projects must obtain

approval from CMHS for transitioning from collaboration development to implementation of service programs. Such approval will be given only if evidence is provided that an effective collaboration has been achieved and that the collaboration has reached a consensus on the programs to initiate. Activities and service programs can include, for example:

- Preventive programs to reduce victimization of vulnerable youth (e.g., anti-bullying, peer mediation, or tolerance promoting programs).

- Resilience enhancement programs for vulnerable youth to better help them cope with their victimization experiences.

- Programs to increase integration and acceptance of vulnerable youth within their families, peer groups, schools, and communities.

- Community-based service programs, including mentoring, psychosocial supportive services, and after-school programs to enhance psychosocial development.

Who Can Apply?

Domestic public and private nonprofit organizations may apply for Vulnerable Youth awards.

The following are eligible to apply:

- Community-based organizations, such as community-based advocacy, health, mental health, social service, faith-based service; parent and teacher associations; consumer and family organizations; and service organizations serving ethnic, cultural, or social minority groups.

- Existing community collaborations, coalitions, and partnerships focusing on youth violence prevention or services to a vulnerable youth population.

- Public or private educational systems, institutions, and agencies.

- Public or private mental health systems, institutions, and agencies, and local law enforcement agencies or affiliated organizations.

- Tribal government units and organizations.

- Other public agencies or nonprofit organizations that can perform the requirements of this GFA.

Because of the overlap of program objectives and the desire to avoid funding multiple youth violence collaborations in the same area, currently funded Safe Schools/Healthy Students and CMHS Coalitions for Prevention PRISM grantees are **not eligible** to apply for this program.

Application

Instructions for completing this grant application are given in two parts. This Guidance for Applicants is Part I.

Part II is a document that has general policies and procedures that apply to all SAMHSA grant and cooperative agreements. You will need to use both Parts I and II for your application.

Part II can be downloaded from the SAMHSA homepage at www.samhsa.gov:

- Click on the link to "Grant Opportunities."
- Click on "Assistance with Grant Applications."
- Click on "Click here for more information on GFA Part II and an online copy of the file."

Part II describes notification procedures to Single-State Agencies (SSA) and State Single Point of Contact (SPOC) (if applicable in your State). Lists of SSAs and SPOCs are available through the SAMHSA website at www.samhsa.gov:

- Click on the link to "Grant Opportunities."
- Click on "Assistance with Grant Applications."
- Click on "List of Directors of Single-State Agencies" or "OMB Single Point of Contact (SPOC) List."

To submit a grant application for this program:

Use application form PHS-5161-1. To download this form, go to the SAMHSA homepage at www.samhsa.gov:

- Click on the link to "Grant Opportunities."
- Click on "Assistance with Grant Applications.
- Click on "Click here to download Forms PHS-5161 and SF-424."

PHS-5161-1 includes the following forms which should be included with your application: a face page (Form 424A) and budget pages (Form 4254B) with instructions, an Assurances Non-Construction Programs form (must be signed), a Certifications form (must be signed), and a Checklist.

Do not follow the instructions on the Program Narrative included in the PHS-5161-1 form. Instead, follow the instructions for the Project Narrative in this Part I Guidance for Applicants.

No Letter of Intent is required.

No funding match is required.

All applicants must address the SAMHSA Participant Protection requirements provisions stated in this GFA in Section I of your application. If the applicant organization is providing direct services to children and youth or is supporting direct services by another organization with Federal funds, you must include sample participant consent forms that conform to SAMHSA Confidentiality and Human Subjects protection requirements as Appendix 3 of your application. If some Participant Protection requirements are not applicable to your project, you must explain why this is the case (e.g., some requirements on service provision might not apply if your organization does not provide or support direct service delivery).

Assemble your application as described in the Section titled Detailed Information on What to Include in Your Application, which follows.

To obtain hard copies of application materials, call the Center for Mental Health Services national clearinghouse, the Knowledge Exchange Network at (800) 789-2647. This is an automated system that requires you to identify the GFA number (SM-02-007) and leave your name and mailing address. Make sure you say your mailing address distinctly.

Where to Send the Application

NOTE: Effective immediately, all applications MUST be sent via a recognized commercial or governmental carrier. Hand-carried applications will not be accepted.

Send the original and two copies of your grant application to:

SAMHSA Programs
Center for Scientific Review
National Institutes of Health
Suite 1040
6701 Rockledge Drive MSC-7710
Bethesda, MD 20892-7710*

*Change the zip code to 20817 if you use express mail or courier service.

Please note:

1. Use application form PHS-5161-1.

2. Be sure to type:
"GFA No. SM-02-007 Youth Violence Prevention for Vulnerable Youth Projects " in Item Number 10 on the face page of the application form.

Application Dates

Your application must be **received** by June 19, 2002.

Applications received after this date will only be accepted for the appropriate receipt date if they have a proof-of-mailing date from the carrier no later than June 12, 2002.

Private metered postmarks are not acceptable as proof of timely mailing. Late applications will be returned without review.

How to Get Help

For questions on *substantive issues regarding the program* and *funding of reviewed applications*, contact:

Malcolm Gordon, Ph.D.
Special Programs Development Branch
Center for Mental Health Services
Substance Abuse and Mental Health
Services Administration
Parklawn Building, Room 17C-05
5600 Fishers Lane
Rockville, MD 20857
(301) 443-2957
E-mail: mgordon@samhsa.gov

or

Pat Shea, M.S.W., M.A.
Center for Mental Health Services
Special Programs Development Branch
5600 Fishers Lane
Room 17-C-05
Rockville, Maryland 20857
Phone: 301-443-3655
FAX: 301-443-7912
E-mail: pshea@samhsa.gov

For questions on budget, eligibility, completion of items on forms, and administrative issues, contact:

Stephen Hudak
Division of Grants Management
Substance Abuse and Mental Health

Services Administration
Parklawn Building, Room 13-103
5600 Fishers Lane
Rockville, MD 20857
(301) 443-9666
E-mail:shudak@samhsa.gov

Cooperative Agreements

Cooperative Agreement Roles

These awards are being made as cooperative agreements, because they require significant Federal staff involvement throughout the project period. CMHS staff and project staff are expected to work together to ensure the success of this cooperative agreement program.

Role of Project Staff

Project staff are expected to implement the project plan as detailed in the application and to consult with CMHS staff on significant modifications or adaptations of the project plan. Project staff are expected to collaborate with CMHS staff in ongoing elaboration and adjustment of the project plan, to collaborate and share experience and expertise with other Youth Violence Prevention Cooperative Agreement sites, and to cooperate with efforts to disseminate project descriptions and results. Project staff are expected to contact and coordinate efforts with other Federally funded youth violence prevention projects in their communities, such as Safe Schools/Healthy Students and Coalitions for Prevention projects.

Role of CMHS Staff

CMHS staff involvement in this program will be required to ensure that the projects meet the program goals. CMHS staff will have overall responsibility for monitoring the conduct and progress of the Youth Violence Prevention Cooperative Agreements and will make recommendations regarding their continued funding. CMHS staff will consult with staff of the project and provide technical assistance on collaboration and consensus building models and activities, on adaptation and implementation of service programs, and on evaluation design and analysis of evaluation data. CMHS staff will review progress reports and conduct site visits, if warranted or desired. CMHS staff will participate in the publication of results in order to make findings available to the field.

Funding Criteria

Funding decisions will be made by September 30, 2002, after reviews of applications by a peer review committee and the CMHS National Advisory Council are completed.

Decisions to fund a grant are based on:

1. The strengths and weaknesses of the application as indicated by a Peer Review Committee, which assigns a numerical evaluation score (the Priority Score) to the application, based on the extent to which the application meets the project requirements as specified in this Guidance for Applicants (GFA), and confirmation of the Review Committee recommendation by the CMHS National Advisory Council.

2. Availability of funds.

3. Priority funding consideration will be given to applications from geographical areas that have not received prior CMHS youth violence funding and to projects proposing youth violence prevention services to vulnerable populations not supported by other projects.

Organizations submitting applications that are funded will receive an official Notice of Grant Award. Applications that are funded will be listed on the SAMHSA web site at www.samhsa.gov.

Post-award Requirements

1. Financial status reports will be required, as specified in the PHS Grants Policy Statement requirements, and the applicant will be informed of the specific requirement when the cooperative agreement is awarded.

2. Semiannual and final progress reports will be required. Reporting requirements will be specified by CMHS staff after award of the cooperative agreements. The purpose of this reporting is to assist the Government Project Officer (GPO) in monitoring project progress.

3. The Government Performance and Results Act of 1993 (GPRA) requires Federal agencies to set and monitor performance standards for agency objectives. As part of GPRA reporting requirements, CMHS will require grantees to report information relevant to the CMHS GPRA program goals. CMHS staff will inform the Project Director of any such reporting requirements.

4. The Project Director and Principle Evaluator, or another staff person knowledgeable about the evaluation, are required to attend an annual 2- or 3-day national meeting of sites (most likely in the Washington D.C., metropolitan area). Travel expenses for the meeting must be included in the budget for Years 1 and 2.

Projects should request 2 years of support and must submit a budget for both Years 1 and 2. Be advised that Year 2 budget funding has usually been at the same level as the Year 1 budget. Budget increases from Year 1 to Year 2 have not been supported. Budget projections for Years 1 and 2 should be planned accordingly. The Federal contribution to the total yearly budgets (direct and indirect costs) may not exceed the maximum award amounts ($150,000) in either year of the grant. SAMHSA does not increase grant awards by additional negotiated indirect cost amounts. Such additional negotiated indirect costs must come out of awarded total costs. Year 2 awards are dependent on availability of funds and progress achieved.

Detailed Information on What to Include in Your Application

In order for your application to be complete and eligible, it must include the following in the order listed. Check off areas as you complete them for your application.

‘ ***1. FACE PAGE***

Use Standard Form 424. See Appendix A in Part II for instructions. In signing the face page of the application, you are agreeing that the information is accurate and complete.

Block 16 refers to Executive Order 12372, establishing a State Single Point of Contact (SPOC) for review of and comment on Federal grant applications by State government agencies. Not all States have a SPOC. A list of States with SPOCs is available at http://www.whitehouse.gov/omb/grants/spoc.html.

‘ ***2. ABSTRACT***

A one-page Project Abstract is required that includes the following headings:

- **Target Population**

Include a description of the type of vulnerable youth targeted by the project and additional relevant target population characteristics (e.g., age, recruitment source, ethnicity).

- **Goals of the Project**

- **Coalition Participation**

Include a description of the major community organizations and constituencies collaborating on the project.

- **Interventions**

Briefly describe the major types of services or service programs that will be implemented during the project.

- **Projected Service Recipients**

State the projected number of youth and/or their families that will be served through the project.

‘ ***3. TABLE OF CONTENTS***

Include page numbers for each major section of your application and for each appendix.

‘ ***4. BUDGET FORM***

Use Standard Form 424A. See Appendix B in Part II for instructions.

‘ ***5. PROGRAM NARRATIVE AND SUPPORT DOCUMENTATION***

These sections describe your project. The Project Narrative is made up of Sections A and B, and supporting materials make up Sections C through F. More detailed information of Sections A through F follows #10 of this checklist.

‘ **Section A - Rationale for and Capacity and Resources to Conduct the Project (Limited to 10 pages)**

‘ **Section B - Implementation Plan for the Project (Limited to 20 pages)**

There are no page limits for the following sections, except for Section I, the Biographical Sketches/Job Descriptions.

G **Section C -** Literature Citations
This section must contain complete citations, including titles and all authors for any literature (if any) you cite in your application.

G **Section D - Budget Justification, Existing Resources, Other Support**
You must provide a narrative justification of the items included in your proposed budget, as well as a description of existing resources and other supports you expect to receive for the proposed project.

G **Section E** - Biographical Sketches and Job Descriptions
-- Include a biographical sketch for the project director and for other key positions. Each sketch should be no longer than two pages. If a person has been identified for a key position in the project, but has not yet been hired, include a letter of commitment from that person, along with the sketch.

-- Include job descriptions for key personnel to be hired. They should be no longer than one page.
-- Sample sketches and job descriptions are listed in Item 6 in the Program Narrative section of the PHS-5161-1.

G **Section F - Confidentiality and SAMHSA Participant Protection (SPP)**
The seven areas you need to address in this section are outlined after the Project Narrative description in this document. **You must complete this section.**

‘ ***6. APPENDICES 1 THROUGH 3***

C Use only the appendices listed below.

- **Do not** use appendices to extend or replace any of the sections of the Program Narrative. (Reviewers will not consider them if you do.)

  Appendix 1: Letters of support or other documentation from coalition participants. **May be no longer than 15 pages.**

  Appendix 2: Letter to Single-State Agency (SSA) (if applicable, see Part II, page 3, and for an on-line listing of SSA contacts, go to www.samhsa.gov/grants/grants.html. Click on link to "Assistance with Grant Applications," then click on link to "List of Directors of Single-State Agencies" for a listing of SSA contacts).

  Appendix 3: Consent form(s) for service recipients and data collection instruments.

- ***7. ASSURANCES***

Non-Construction Programs. Use Standard form 424B found in PHS-5161-1. See Part II, page 9. Standard Form 424B is available online through a link at www.samhsa.gov/grants/grants.html. (Click on link to "Assistance with Grant Applications," then click on link to "Click here to download Forms PHS-5161 and SF-424" for access to Assurance of Compliance Forms.)

In addition, you must file or have on file a Civil Right and Non-Discrimination Assurance Form (HHS 690, available at http://www.hhs.gov/ocr/pregrant/forms.html) with the DHHS Office for Civil Rights. Indicate on the appropriate lines on the SAMHSA Checklist the date you filed the assurance.

- ***8. CERTIFICATIONS***

See Part II, page 9. A list of certifications is included in the PHS form 5161-1. PHS-5161 is available online through a link at www.samhsa.gov/grants/grants.html.

- ***9. DISCLOSURE OF LOBBYING ACTIVITIES***

SAMHSA's policy does not allow lobbying. Please see Part II for lobbying prohibitions.

- ***10. CHECKLIST***

See Appendix C in Part II for instructions.

The Public Health Impact Statement is discussed on pages 3-4 of Part II.

Project Narrative– Sections A Through F Highlighted

The description of your proposed project must address the requirements detailed in Sections A and B of this GFA. Corresponding Sections A and B of your application should describe your qualifications and capacity to conduct the project and what you intend to do in your project, addressing each section of the project requirements. Below you will find detailed information on how to respond to Sections A and B:

- Section A may be no longer than 10 pages, and Section B may be no longer than 20 pages. Restrictions on type size are stated in Part II instructions, page 8.

- Your application will be reviewed by a peer review committee comprised of individuals with experience in service delivery, research, administration, and/or advocacy in the areas of youth violence and youth service programs. The peer review committee will assign a point value to your application, based on how well you address the project requirements specified in Sections A and B that follow. **It is important that your application present an adequate response to each of the project requirement sections, because funding decisions are most strongly determined by the point total assigned to your application by the review committee.**

- The number of points after each main heading shows the maximum points a review committee may assign to that category.

- You will receive a summary report (a Summary Statement) of strengths and weaknesses of your application with respect to the project requirement, as viewed by the review committee, several weeks after the review committee meeting. The Summary Statement will also show a Priority Score, which is a transformed score, on a 100 to 500 scale, of the point total awarded to your application by the review committee (with 100 being the best score and 500 the worst score). The review committee will also evaluate the adequacy of your Participant Protection procedures. Applications with inadequate Participant Protection procedures can not be funded, unless the procedures are corrected.

- **Additional material is available in support of this GFA. This material is included in Appendix A and in the grant application packet. It is also available online at the SAMHSA web site, www.samhsa.gov/grants/grants.html. (Click on Currently Available Grant Opportunities, FY 2001.)**

YOUTH VIOLENCE PREVENTION FOR VULNERABLE YOUTH PROJECT REQUIREMENTS

Vulnerable Youth projects are expected to develop a community-based approach to address victimization of one of the vulnerable youth populations specified in the Program Overview of this section of the GFA. The project should:

- Develop a **coalition** of critical community organizations, groups, and constituencies to address violence and victimization directed at the target population of vulnerable youth.

- Reach **consensus** among coalition partners **on a strategic plan** of activities and programs to address victimization of the vulnerable population.

- Develop activities to increase **community awareness** of victimization experiences and the consequences of such experiences on vulnerable youth and **support** for efforts to reduce victimization of vulnerable youth.

- **Select and implement** a specific intervention program or approach to reduce victimization of, or the impact of victimization on, the vulnerable youth population.

The application will be evaluated by an expert review committee, according to how well the application addresses the project requirements specified in **each** section of this GFA. The Project Narrative must follow the same sequence of topics as stated in this project requirements section.

Section A: Rationale for and Capacity and Resources to Conduct the Project (100 points; limited to 10 pages)

The Youth Violence Prevention for Vulnerable Youth program requires that the applicant organization or its partners address a vulnerable youth population in need of violence prevention services, have experience with and access to the population, and have the capacity to conduct a youth violence prevention project. **Reviewers will award points on the basis of the adequacy of the proposed project in addressing the criteria in the following section**. The applicant must score at least 70 points in Section A to qualify for further consideration. The application will not undergo review of Section B if it has not scored 70 points or more in

Section A of the Project Narrative portion of the application, and it will not be considered for funding.

Identify the population of vulnerable youth targeted by the project, and justify its need for violence prevention services:

- The target population must be one of the vulnerable youth populations specified in the Program Overview of this Section I: youth with physical disabilities or developmental limitations; gay, lesbian, bisexual, and transgender youth; youth in out-of-home residence; youth of mixed racial parentage; recent immigrants; and religious minority groups.

- **Not all vulnerable youth experience victimization.** Discuss the need for intervention to reduce the prevalence or seriousness of victimization of the identified vulnerable youth population, using available systematic information, such as survey or other community-level data, clinical or service experience, or interviews with youth or key informants, describing:

  - The numbers of such youth in the community.

  - The prevalence and seriousness of victimization experiences and the mental health effects of victimization of the vulnerable youth population.

  - The absence of services for, or barriers to accessing services by, the identified vulnerable youth. population

  - The community's social environment with respect to the vulnerable children and youth.

  - Other characteristics relevant to the population's victimization, access to services, or delivery of services.

Describe the experience of the applicant organization or coalition partners in advocacy or services to the target population, including:

- The length of involvement with, history of advocacy for, and efforts in the community to reduce discrimination, stigmatization, harassment, and other forms of victimization directed at the vulnerable target population.

- Current outreach efforts to the target population and types of programs and services provided.

- Representation of the target population in the organization(s).

Describe existing or proposed methods that will be used to access the target population. Discuss existing agreements with important community service systems, organizations, or constituencies, such as schools, social service providers, religious institutions, or families of vulnerable youth, that will facilitate provision of violence prevention services to the target population.

Describe prior or current experience of collaboration partners in youth violence prevention/youth development activities.

Describe additional expertise in youth violence prevention that is available or will be recruited for the project.

Describe the organization's administrative and financial experience and staff and resources that will be dedicated to the project, including:

- Prior organizational experience managing grants or awards.

- Experience of the Project Director with prior funded projects.

  If a Project Director has not been selected, the application should include a position description for the project director position in Section E.

- Additional staff and other resources dedicated to administrative and fiscal management activities of the grant and their relevant experience.

Section B: Implementation Plan for the Project (100 points; limited to 20 pages)

Applicants are expected to propose a project to effectively implement a violence prevention project for the vulnerable youth population. **Reviewers will award points on the basis of the adequacy of the proposed project in addressing the criteria in each of the following sections.**

(1) Development of an Effective Coalition (20 Points)

- Describe the major stakeholders (organizations, service systems, and constituencies) concerned with the targeted vulnerable youth population that will participate in the coalition, and discuss their history of collaboration. Put documents indicating their willingness to participate in a coalition (e.g., letters of support, Memoranda of Understanding) in Appendix 1.

- Describe strategies to recruit and engage additional critical stakeholders concerned with youth in the community or with providing access to the target youth population.

- Identify individual(s) or organizations that will provide leadership for the coalition, and discuss their background, experience, and qualifications to effectively organize and/or provide leadership for a youth violence prevention collaboration for the vulnerable youth population.

Effective collaborations collect reliable information for planning, monitoring, and modification of activities and intervention programs, such as information on victimization experiences and their impact, barriers to accessing services, and availability and effectiveness of services.

- Describe any existing, accessible information sources, such as existing agencies records, prior surveys, and other sources, on:

  Victimization of the vulnerable youth and the impact of victimization.

  Community attitudes, support, and resources for prevention of violent victimization.

  Other information relevant to intervention planning.

- If available information is not adequate for project purposes, discuss plans to gather or develop information that would inform coalition decision makers in developing an effective approach to reducing victimization of vulnerable youth and the effects of such victimization. This plan should indicate what types of information will be collected, the sources of such information, who will collect the information, and how the collected information will be used to guide coalition goal setting, planning, activities, and service program implementation.

- Describe involvement of youth and/or their families targeted for services in the violence prevention collaboration.

(2) Implementation of an Effective Intervention Approach (30 Points)

State one or two major goals for the project to accomplish during the project period in each of the following areas:

- Increasing awareness in the community or in important social settings (e.g., schools or the family) of the impact of victimization on the vulnerable youth population and increasing tolerance, and decreasing discrimination and/or stigmatization directed at the vulnerable youth.

- Reducing victimization or the impact of victimization experienced by vulnerable youth.

Provide either process-type goals (e.g., establish a coalition of the major organizations and constituencies that can play a significant role in reducing victimization in the vulnerable target population) or outcome-type goals (e.g., targeted reduction in the frequency of types of victimization of the vulnerable targeted youth population). State goals that can be evaluated and are feasible, given the project's resources and social context in which the project is operating (e.g., cooperation of schools for school-based projects; achieving a degree of community acceptance or tolerance of gay/lesbian youth may be more difficult to achieve in communities with a history of intolerance than in communities with a greater degree of acceptance of diversity).

Describe a preliminary plan to achieve the goals you have identified. *It is expected that the preliminary plan presented may be significantly modified during the course of the project, due to additional input from coalition partners and the community, outcomes of implemented activities and programs, and other events and situations that arise within the project or in the community.* The proposed preliminary plan should:

- Describe prior experience or expertise of coalition partners in developing community awareness and support, such as social marketing or media campaigns.

- Describe a preliminarily proposed set of activities and/or programs to increase community awareness or awareness of significant constituencies and support for efforts to reduce victimization of the vulnerable youth, such as public relations campaigns and community forums.

- Describe prior and existing community efforts to address victimization of, or to support, the vulnerable youth population.

- Describe a preliminary set of activities and/or programs to reduce the prevalence and/or consequences of violence and other victimization of vulnerable youth.

- Identify and concisely describe specific service program(s) or types of programs or activities that could be implemented in the community to achieve the violence reduction goals of the project. Such programs could include anti-bullying or other violence prevention programs, diversity tolerance programs, peer mediation or other peer support programs, resilience enhancement, mental health and substance abuse interventions, or other positive youth and family development service programs.

- Describe the rationale for nominating specific program(s) or types of programs or activities to implement. The rationale can be stated in terms of needs of vulnerable youth, applicability to the targeted group, likely effectiveness and impact of the program(s), and resources or training available for program implementation. Applicants should support the proposed implementation plan presented with any documentation or evidence that the proposed plan of activities and programs is likely to be effective in achieving positive outcomes in each of these component areas. Evidence can include a summary of: (1) published evaluations or research on proposed activities or programs or the underlying conceptualization of the program(s), (2) evidence for consensus of the effectiveness of activities or programs among service providers or consumers, or (3) documented outcome effectiveness of the activities and programs in local implementations of an intervention approach. Criteria for evaluating likely effectiveness of service programs are discussed in Appendix A.

- Describe involvement or planned involvement of youth and/or their families in selection and implementation of intervention programs.

- Describe expert consultation that will be obtained on selection of service programs to implement, and/or on training for implementation, and/or on actual

implementation of intervention programs. Include letters of commitment from primary consultants to assist the project in Appendix 1.

(3) Project Monitoring and Evaluation (20 Points)

The primary purpose of the evaluation of the Youth Violence Prevention for Vulnerable Youth projects is to gather information which will be useful to the coalition in monitoring progress of the project, assessing success of the project components, and informing decision making by the coalition. The evaluation staff should have the background, training, and experience to conduct a competent and useful evaluation. Projects must budget at least 10 percent of the total budget, and no more than 15 percent of the total budget, to project evaluation.

Describe a preliminary plan to monitor the progress of the coalition and its activities and programs and the success of the project in achieving its goals. *This preliminary plan is subject to change during the course of the project, as it is expected that the final evaluation procedures used in the project would be developed with input from collaboration participants and community constituencies.*

Describe:

- Useful process or outcome indicators that would enable the collaboration to monitor progress on collaborative functioning and the effectiveness of its activities and programs.

- Methodological approaches to be used to collect evaluation information.

- Plans for summarizing and reporting evaluation data.

Describe how evaluation data will be used by the coalition for planning and monitoring its activities and programs.

Describe the qualifications and experience of the project's evaluation staff. If an Evaluator has not yet been selected, a position description listing the minimum qualification and experience requirements should be attached in Section I.

Describe plans to obtain input from the targeted vulnerable youth and/or their families in developing the evaluation plan.

Describe plans to ensure that the evaluation plan and procedures are culturally and socially appropriate, such as being acceptable to members of cultural and social groups in the target population and being appropriate indicators for the diverse groups in the target population.

(4) Plan for Sustainability (15 Points)

Resources that can be developed to support the continuance of youth violence prevention programs include: (1) human and community resources (e.g., dedicated staff, expertise and training of service providers, school and community support); (2) increased organizational capacity of the coalition to address goals and recruit resources; (3) funding (e.g., grant support, service reimbursement); and (4) other resources (e.g., legislative or policy changes and support; resource contributions, such as equipment or information technology resources).

Describe existing human, funding, and other resources for sustaining the coalition and its activities.

Describe plans to increase the organizational capacity of the coalition to recruit resources (e.g., development of fund raising capacity, recruitment of community and professional volunteers).

Describe plans to continue implemented intervention programs, including plans to develop additional human, funding, and supportive resources.

(5) Community Diversity (15 Points)

Youth Violence Prevention for Vulnerable Youth projects are expected to:

- Include representatives of the major ethnic/cultural/social constituencies in the coalition.

- Develop and implement outreach methods to facilitate involvement of the diverse ethnic/cultural/social groups in the targeted vulnerable youth population.

- Increase the competence of the project staff, collaboration participants, and service providers with respect to the culture and other forms of diversity (such as age or sexual orientation) of the target population, such as by

recruitment of staff of similar background, or work or other relevant experience with the culture/ethnicity/
social characteristics, or staff training in cultural competence, or other aspects of addressing diversity.

- Monitor the effectiveness of collaboration activities and service programs with different ethnic/cultural/social groups in the community.

Describe the major racial/ethnic/cultural/social groups in the target youth population, and indicate which groups are targeted by the project for receipt of intervention services.

Describe the extent to which coalition participants (organizations or individuals representing constituencies) reflect the ethnic/cultural/social diversity of the target service population.

Describe plans to ensure participation of the diverse ethnic/cultural/social groups in the coalition and in selection and implementation of the intervention program.

Describe plans to ensure participation of non-English speaking or limited english speaking youth and families, if applicable.

Describe the existing diversity of project staff and service providers and their proficiency in the languages and cultures of the target population.

Describe plans to provide training on diversity issues relevant to the ethnic/cultural/social groups in the target community. Describe qualifications of the training staff on diversity issues.

Describe plans to monitor participation of the various ethnic/cultural/social groups in collaboration activities and services.

Describe plans to provide feedback to community constituencies on the coalition and its activities in a linguistic and culturally appropriate manner.

Confidentiality and SAMHSA Participant Protections (SPP)

You must address seven areas regarding confidentiality and SAMHSA participant protection in your supporting documentation. However, no points will be assigned to this section.

This information will:

- Reveal if the protection of participants is adequate or if more protection is needed.
- Be considered when making funding decisions.

Some projects may expose people to risks in many different ways. In Section I of your application, you will need to:

- Report any possible risks for people in your project.
- State how you plan to protect them from those risks.
- Discuss how each type of risk will be dealt with, or why it does not apply to the project.

The following seven issues must be discussed:

- Protection of Clients and Staff from Potential Risks:

- Identify and describe any foreseeable physical, medical, psychological, social, legal, or other risks or adverse effects.

- Discuss risks which are due either to participation in the project itself, or to the evaluation activities.

- Describe the procedures that will be followed to minimize effects of or protect participants against potential health or confidentiality risks. Make sure to list potential risks in addition to any confidentiality issues.

- Give plans to provide help, if needed, if there are adverse effects on participants.

- Describe alternative treatments and procedures that might be beneficial to the subjects, where appropriate.

- Offer reasons if you do not use other beneficial treatments.

Ù Fair Selection of Participants:

- Describe the target population(s) for the proposed project. Include age, gender, and racial/ethnic background. Address other important factors, such as homeless youth, foster children, children of substance abusers, pregnant women, or other special population groups.

- Explain the reasons for using special types of participants, such as pregnant women, children, institutionalized or mentally disabled persons, prisoners, or persons likely to be vulnerable to HIV/AIDS.

- Explain the reasons for <u>including or excluding</u> participants.

- Explain how you will recruit and select participants. Identify who will select participants.

Ú Absence of Coercion:

- Explain if participation in the project is voluntary or required. Identify possible reasons why it is required (e.g., court orders requiring people to participate in a program).

- State how participants will be awarded money or gifts if you plan to pay them.

- State how volunteer participants will be told that they may receive services and incentives, even if they do not complete the study.

Û Data Collection:

- Identify from whom you will collect data (e.g., participants themselves, family members, teachers, and others). Explain how you will collect data and list the site. For example, will you use school records, interviews, psychological assessments, observation, questionnaires, or other sources?

- Identify what, if any, type of specimen (e.g., urine, blood) will be used. State if the material will be used just for evaluation and research or for other uses. Also, if needed, describe how the material will be monitored to ensure the safety of participants.

- Provide in Appendix 3 copies of <u>all</u> available data collection instruments and interview protocols that you plan to use.

Ü Privacy and Confidentiality:

- Explain how you will ensure privacy and confidentiality. Include who will collect data and how it will be collected.

- Describe:
  -How you will use data collection instruments.
  - Where data will be stored.
  - Who will or will not have access to information.
  - How the identity of participants will be kept private (e.g., by using a coding system on data records, limiting access to records, or storing identifiers separately from data.

NOTE: If applicable, grantees must agree to maintain the confidentiality of alcohol and drug abuse client records, according to the provisions of Title 42 of the Code of Federal Regulations, Part II.

Ý Adequate Consent Procedures:

- List what information will be given to people who participate in the project. Include the type and purpose of their participation. Include how the data will be used and how you will keep the data private.

- State:
  - Whether their participation is voluntary.
  - Their right to leave the project at any time without problems.
  - Risks from the project.
  - Plans to protect clients from these risks.

- Explain how you will get consent for youth, the elderly, people with limited reading skills, and people who do not use English as their first language.

  Note: If the project poses potential physical, medical, psychological, legal, social, or other risks, you should get written, informed consent.

- Indicate whether you will get informed consent from participants or from their parents or legal guardians. Describe how the consent will be documented. For example: Will you read the consent forms? Will you ask prospective participants questions to be sure they understand the forms? Will you give them copies of what they sign?

- Include sample consent forms in your Appendix 3. If needed, provide English translations.

Note: Never imply that the participant waives or appears to waive any legal rights, may not end involvement with the project, or may release your project or its agents from liability for negligence.

- Describe whether separate consents will be obtained for different stages or parts of the project. For example, will they be needed for both the treatment intervention and for the collection of data. Will individuals who do not consent to having individually identifiable data collected for evaluation purposes be allowed to participate in the project?

Þ Risk/Benefit Discussion:

- Discuss why the risks are reasonable when compared with expected benefits and importance of the knowledge from the project.

Section II: School-based Mental Health Project Requirements

Program Overview

A contributing factor to peer and school violence is the presence of unrecognized and untreated mental health problems in youth at risk for perpetration of violence. In addition, youth who experience violent victimization, either in the school setting or outside the school, may experience or exacerbate a range of mental health problems that can interfere with school functioning. Schools are the service system with the most contact with children and youth, and they can promote healthy development in youth by supporting mentally healthy individual functioning and positive prosocial interactions among youth in the school setting and by identifying and providing mental health services to youth whose functioning is compromised by mental health problems. Prevention, identification, and treatment intervention programs supporting positive youth mental health can be effective in reducing violent victimization and perpetration by young people. A number of different approaches to providing these types of mental health services are used in schools.

The School-based Mental Health Projects program will support school-wide or school system-wide projects that implement all of the following component activities and programs:

- Adoption of a mental health promotion approach by the school community.
- Implementation of mental health promotion/prevention programs or services for the whole school community.
- Identification and assessment of children/youth in the schools with mental health problems.
- Provision of treatment and psychosocial services to children with mental health problems in the school, or referrals for such services.

These projects must have significant involvement and support of school administrators, teachers, students, parents, and the community service sector.

Who Can Apply?

School-based Mental Health Project applicants are restricted to public and private schools and school systems. This eligibility restriction is necessary to ensure that the school-based mental health program is not marginalized because of lack of support by school administrative and instructional staff.

Because of the overlap of program objectives and the desire to avoid funding multiple youth violence collaborations in the same area, currently funded Safe Schools/Healthy Students and CMHS Coalitions for Prevention PRISM grantees are **not eligible** to apply for this program.

Application

Instructions for completing this grant application are given in two parts. This Guidance for Applicants is Part I. Part II is a document that has general policies and procedures that apply to all SAMHSA grant and cooperative agreements. You will need to use both Parts I and II for your application.

Part II can be downloaded from the SAMHSA homepage at www.samhsa.gov:

- Click on the link to "Grant Opportunities."
- Click on "Assistance with Grant Applications."
- Click on "Click here for more information on GFA Part II and an online copy of the file."

Part II describes notification procedures to Single-State Agencies (SSA) and State Single Point of Contact (SPOC) (if applicable in your State). Lists of SSAs and SPOCs are available through the SAMHSA website at www.samhsa.gov:

- Click on the link to "Grant Opportunities."
- Click on "Assistance with Grant Applications."
- Click on "List of Directors of Single-State Agencies" or "OMB Single Point of Contact (SPOC) List."

To submit a grant application for this program:

Use application form PHS-5161-1. To download this form go to the SAMHSA homepage at www.samhsa.gov:

- Click on the link to "Grant Opportunities."
- Click on "Assistance with Grant Applications.
- Click on "Click here to download Forms PHS-5161 and SF-424."

PHS-5161-1 includes the following forms which should be included with your application: a face page (Form 424A) and budget pages (Form 4254B) with instructions, an Assurances Non-Construction Programs form (must be signed), Certifications form (must be signed), and a Checklist.

Do not follow the instructions on the Program Narrative included in the PHS-5161-1 form. Instead, follow the instructions for the Project Narrative in this Part I Guidance for Applicants.

No Letter of Intent is required.

No funding match is required.

All applicants must address the SAMHSA Participant Protection requirements provisions stated in this GFA in Section I of your application. If the applicant organization is providing direct services to children and youth or is supporting direct services by another organization with Federal funds, you must include sample participant consent forms that conform to SAMHSA Confidentiality and Human Subjects protection requirements as Appendix 3 of your application. If some Participant Protection requirements are not applicable to your project, you must explain why this is the case (e.g., some requirements on service provision might not apply if your organization does not provide or support direct service delivery).

Assemble your application as described in the Section titled Detailed Information on What to Include in Your Application, which follows.

To obtain hard copies of application materials, call the Center for Mental Health Services national clearinghouse, the Knowledge Exchange Network at (800) 789-2647. This is an automated system that requires you to identify the GFA number (SM-02-007) and leave your name and mailing address. Make sure you say your mailing address distinctly.

Where to Send the Application

NOTE: Effective immediately, all applications MUST be sent via a recognized commercial or governmental carrier. Hand-carried applications will not be accepted.

Send the original and two copies of your grant application to:

SAMHSA Programs
Center for Scientific Review
National Institutes of Health
Suite 1040
6701 Rockledge Drive MSC-7710
Bethesda, MD 20892-7710*

***Change the zip code to 20817 if you use express mail or courier service.**

Please note:

1. Use application form PHS-5161-1.

2. Be sure to type:
"GFA No. SM-02-007 Youth Violence Prevention Cooperative Agreements: School-based Mental Health Projects" in Item Number 10 on the face page of the application form.

Application Dates

Your application must be **received** by June 19, 2002.

Applications received after this date will only be accepted for the appropriate receipt date if they have a proof-of-mailing date from the carrier no later than June 12, 2002.

Private metered postmarks are not acceptable as proof of timely mailing. Late applications will be returned without review.

How to Get Help

For questions on *substantive issues regarding the program* and *funding of reviewed applications*, contact:

Malcolm Gordon, Ph.D.
Special Programs Development Branch
Center for Mental Health Services
Substance Abuse and Mental Health
Services Administration
Parklawn Building, Room 17C-05
5600 Fishers Lane

Rockville, MD 20857
(301) 443-2957

E-mail: mgordon@samhsa.gov

For questions on budget, eligibility, completion of items on forms, and administrative issues, contact:

Stephen Hudak
Division of Grants Management
Substance Abuse and Mental Health
Services Administration
Parklawn Building, Room 13-103
5600 Fishers Lane
Rockville, MD 20857
(301) 443-9666
E-mail:shudak@samhsa.gov

Cooperative Agreements

Cooperative Agreement Roles

These awards are being made as cooperative agreements, because they require significant Federal staff involvement throughout the project period. CMHS staff and project staff are expected to work together to ensure the success of this cooperative agreement program.

Role of Project Staff

Project staff are expected to implement the project plan as detailed in the application and to consult with CMHS staff on significant modifications or adaptations of the project plan. Project staff are expected to collaborate with CMHS staff in ongoing elaboration and adjustment of the project plan, to collaborate and share experience and expertise with other Youth Violence Prevention Cooperative Agreement sites, and to cooperate with efforts to disseminate project descriptions and results. Project staff are expected to contact and coordinate efforts with other Federally funded youth violence prevention projects in their communities, such as Safe Schools/Healthy Students and Coalitions for Prevention projects.

Role of CMHS Staff

CMHS staff involvement in this program will be required to ensure that the projects meet the program goals. CMHS staff will have overall responsibility for monitoring the conduct and progress of the Youth Violence Prevention Cooperative Agreements and will make recommendations regarding their continued funding. CMHS staff will consult with staff of the project and provide technical assistance on collaboration and consensus building models and activities, on adaptation and implementation of service programs, and on evaluation design and analysis of evaluation data. CMHS staff will review progress

reports and conduct site visits, if warranted or desired. CMHS staff will participate in the publication of results in order to make findings available to the field.

Funding Criteria

Funding decisions will be made by September 30, 2002, after reviews of applications by a peer review committee and the CMHS National Advisory Council are completed.

Decisions to fund a grant are based on:

1. The strengths and weaknesses of the application as indicated by a Peer Review Committee, which assigns a numerical evaluation score (the Priority Score) to the application, based on the extent to which the application meets the project requirements as specified in this Guidance for Applicants (GFA), and Confirmation of the Review Committee recommendation by the CMHS National Advisory Council

2. Availability of funds.

Organizations submitting applications that are funded will receive an official Notice of Grant Award. Applications that are funded will be listed on the SAMHSA web site at www.samhsa.gov.

Post-award Requirements

1. Financial status reports will be required, as specified in the PHS Grants Policy Statement requirements, and the applicant will be informed of the specific requirement when the cooperative agreement is awarded.

2. Semiannual and final progress reports will be required. Reporting requirements will be specified by CMHS staff after award of the cooperative agreements.

3. The Government Performance and Results Act of 1993 (GPRA) requires Federal agencies to set and monitor performance standards for agency objectives. As part of GPRA reporting requirements, CMHS will require grantees to report information relevant to the CMHS GPRA program goals. CMHS staff will inform the Project Director of any such reporting requirements.

4. The Project Director and Principle Evaluator, or another staff person knowledgeable about the evaluation, are required to attend an annual 2- or 3-day national meeting of sites (most likely in the Washington D.C., metropolitan area). Travel expenses for the meeting must be included in the budget for Years 1 and 2.

Projects should request 2 years of support and must submit a budget for both Years 1 and 2. Be advised that Year 2 budget funding has usually been at the same level as the Year 1 budget. Budget increases from Year 1 to Year 2 have not been supported. Budget projections for Years 1 and 2

should be planned accordingly. The Federal contribution to the total yearly budgets (direct and indirect costs) may not exceed the maximum award amounts ($200,000) in either year of the grant. SAMHSA does not increase grant awards by additional negotiated indirect cost amounts. Such additional negotiated indirect costs must come out of awarded total costs. Year 2 awards are dependent on availability of funds and progress achieved.

Detailed Information on What to Include in Your Application

In order for your application to be complete and eligible, it must include the following in the order listed. Check off areas as you complete them for your application.

‘ *1. FACE PAGE*

Use Standard Form 424. See Appendix A in Part II for instructions. In signing the face page of the application, you are agreeing that the information is accurate and complete.

Block 16 refers to Executive Order 12372, establishing a State Single Point of Contact (SPOC) for review of and comment on Federal grant applications by State government agencies. Not all States have a SPOC. A list of States with SPOCs is available at http://www.whitehouse.gov/omb/grants/spoc.html.

‘ *2. ABSTRACT*

A **one-page** Project Abstract is required that includes the following headings:

- **Goals of the Project**

- **Target Population**

Identify the schools or school system involved and relevant characteristics of students (e.g., age, income characteristics, risk characteristics).

- **Collaborating Partners (if any)**

- **Interventions**

Briefly describe the major types of services or service programs that will be implemented during the project.

- **Projected Service Recipients**

State the projected number of youth and/or their families that will be served through the project.

‘ *3. TABLE OF CONTENTS*

Include page numbers for each major section of your application and for each appendix.

‘ ***4. BUDGET FORM***

Use Standard Form 424A. See Appendix B in Part II for instructions.

‘ ***5. PROGRAM NARRATIVE AND SUPPORT DOCUMENTATION***

These sections describe your project. The Project Narrative is made up of Sections A and B, and supporting materials make up Sections C through F. More detailed information on Sections A through F follows #10 of this checklist**.**

‘ **Section A - Capacity and Resources to Conduct the Project (Limited to 10 pages)**

‘ **Section B - Implementation Plan for the Project (Limited to 20 pages)**

There are no page limits for the following sections, except for Section I, the Biographical Sketches/Job Descriptions.

G **Section C - Literature Citations**

This section must contain complete citations, including titles and all authors for any literature (if any) you cite in your application.

G **Section D - Budget Justification, Existing Resources, Other Support**

You must provide a narrative justification of the items included in your proposed budget, as well as a description of existing resources and other supports you expect to receive for the proposed project.

G **Section E - Biographical Sketches and Job Descriptions**

-- Include a biographical sketch for the project director and for other key positions. Each sketch should be no longer than two pages. If a person has been identified for a key position in the project, but has not yet been hired, include a letter of commitment from that person, along with the sketch.

-- Include job descriptions for key personnel to be hired. They should be no longer than one page.

-- Sample sketches and job descriptions are listed in Item 6 in the Program Narrative section of the PHS-5161-1.

G **Section F - Confidentiality and SAMHSA Participant Protection (SPP)**

The seven areas you need to address in this section are outlined after the Project Narrative description in this document. **You must complete this section.**

‘ ***6. APPENDICES 1 THROUGH 3***

- Use only the appendices listed below.
- **Do not** use appendices to extend or replace any of the sections of the Program Narrative. (Reviewers will not consider them if you do.)

Appendix 1: Letters of support or other documentation from the school system and school administration, representatives of school staff and other community constituencies, and service providers. **May be no longer than 15 pages.**

Appendix 2: Letter to Single-State Agency (SSA) (if applicable; see Part II, page 3, and for an online listing of SSA contacts, go to www.samhsa.gov/grants/grants.html. Click on link to "Assistance with Grant Applications," then click on link to "List of Directors of Single-State Agencies" for a listing of SSA contacts).

Appendix 3: Consent form(s) for service recipients and data collection instruments.

‘ ***7. ASSURANCES***

Non - Construction Programs. Use Standard form 424B found in PHS-5161-1. See Part II, page 9. Standard Form 424B is available online through a link at www.samhsa.gov/grants/grants.html. (Click on link to "Assistance with Grant Applications," then click on link to "Click here to download Forms PHS-5161 and SF-424" for access to Assurance of Compliance Forms.)

In addition, you must file or have on file a Civil Right and Non-Discrimination Assurance Form (HHS 690, available at http://www.hhs.gov/ocr/pregrant/forms.html) with the DHHS Office for Civil Rights. Indicate on the appropriate lines on the SAMHSA Checklist the date you filed the assurance.

‘ ***8. CERTIFICATIONS***

See Part II, page 9. A list of certifications is included in the PHS form 5161-1. PHS-5161 is available online through a link at www.samhsa.gov/grants/grants.html.

‘ ***9. DISCLOSURE OF LOBBYING ACTIVITIES***

SAMHSA's policy does not allow lobbying. Please see Part II for lobbying prohibitions.

‘ ***10. CHECKLIST***

See Appendix C in Part II for instructions.

The Public Health Impact Statement is discussed on pages 3-4 of Part II.

Project Narrative–Sections A Through F Highlighted

The description of your proposed project must address the requirements detailed in Sections A and B of this GFA. Corresponding Sections A and B of your application should describe your qualifications and capacity to conduct the project and what you intend to do in your project, addressing each section of the project requirements. Below you will find detailed information on how to respond to Sections A and B:

- Section A may be no longer than 10 pages, and Section B may be no longer than 20 pages. Restrictions on type size are stated in Part II instructions, page 8.

- Your application will be reviewed by a peer review committee comprised of individuals with experience in service delivery, research, administration, and/or advocacy in the areas of youth violence and youth service programs. The peer review committee will assign a point value to your application, based on how well you address the project requirements specified in Sections A through B that follow. **It is important that your application present an adequate response to each of the project requirement sections, because funding decisions are most strongly determined by the point total assigned to your application by the review committee.**

- The number of points after each main heading shows the maximum points a review committee may assign to that category.

- You will receive a summary report (a Summary Statement) of strengths and weaknesses of your application with respect to the project requirement, as viewed by the review committee, several weeks after the review committee meeting. The Summary Statement will also show a Priority Score, which is a transformed score on a 100 to 500 scale, of the point total awarded to your application by the review committee (with 100 being the best score and 500 the worse score). The review committee will also evaluate the adequacy of your Participant Protection procedures. Applications with inadequate Participant Protection procedures can not be funded, unless the procedures are corrected.

- **Additional material is available in support of this GFA. This material is included in Appendix B and in the grant application packet. It is also available online at the SAMHSA web site, www.samhsa.gov/grants/grants.html. (Click on Currently Available Grant Opportunities, FY 2001.)**

SCHOOL-BASED MENTAL HEALTH PROJECT REQUIREMENTS

School-based Mental Health Projects are expected to:

- Develop a comprehensive, school-wide approach to mental health promotion in the school setting.

- Increase the level of commitment of school administrators, teachers and other school staff, students, and families to a comprehensive, school-based approach to positive mental health of students.

- Significantly expand the number, scope, and impact of school-based mental health activities and programs provided to the school population to make them more comprehensive and effective in the areas of:

  - Mental health prevention/promotion.

  - Identification/assessment of mental health problems.

  - Treatment/psychosocial services for mental health problems.

- Monitor and evaluate the progress of the components of the school-based mental health project.

- Achieve long-term fiscal and institutional sustainability of the school-based mental health programs and activities.

Projects can be proposed for individual schools, clusters of schools, or an entire school system, depending on the level of available administrative, staff, and consumer support for implementing comprehensive mental health services in school settings.

Projects can be proposed at the elementary, junior high/middle school, or high school levels.

The application must include a Project Narrative that describes the accomplishments and capacities of existing school-based mental health programs and plans to significantly expand or improve the mental health programs in the school(s).

The application will be evaluated by an expert review committee, according to how well the application addresses the project requirements specified in **each** section of this GFA. The Project Narrative must follow the same sequence of topics as stated in this project requirements section.

Section A: Capacity and Resources to Conduct the Project (100 points; limited to 10 pages)

The School-based Mental Health program requires that the applicant organization have the capacity, support of the school administration and constituencies in the school community, and sufficient resources to develop a comprehensive, school-wide approach to mental health promotion. **Reviewers will award points on the basis of the adequacy of the proposed project in addressing the criteria in the following section**. The applicant must score at least 70 points in Section A to qualify for further consideration. The application will not undergo review of Section B if it has not scored 70 points or more in Section A of the Project Narrative portion of the application, and it will not be considered for funding.

Seeking and receiving mental health services are stigmatized in many communities. To avoid marginalization of school-based mental health programs, such programs need to be embraced by the school community. To develop support for a school-wide mental health promotion approach, key administrative policy makers (principal and/or superintendent and/or school board), teachers, pupil services staff, other school staff, students, and parents should be committed to the approach or plans proposed to recruit and involve these constituency groups.

Discuss acceptance of and planned participation in a school-based mental health promotion approach by the following key constituencies:

- Decision making administrators.
- Teachers.
- Pupil support services staff.
- Special education staff (if applicable).
- Mental health service providers.

Document willingness to support and engage in school mental health promotion programs and activities by representatives of these constituencies (e.g., letters of support, Memoranda of Understanding) in Appendix 1.

Provide documentation of willingness of out-of-school mental health service providers to provide mental health services through the school, if they will be used in the project, in Appendix 1.

Briefly describe prior experience and major accomplishments to date of the school/school system with mental health promotion/intervention and current resources (programs, staff, contracts) available for mental health promotion in the school(s), including mental health services available within the schools or in the community by referral from schools.

Describe involvement of consumer groups, especially students and/or their families, in the planning and implementation of school-based mental health services.

Indicate which individuals and organizational component or committee will administer and monitor the school-based mental health promotion program in the school(s). Describe their decision making authority and the support given by school administrators to this administrative entity.

Describe the administrative and financial experience and staff and resources that will be dedicated to the management of the administrative aspects of the project, such as completing progress reports, hiring and supervising staff, and fiscally managing Federal funds, including:

- Prior experience managing grants or awards.

- Experience of the Project Director with prior funded projects. If a Project Director has not been selected, the application should include a position description for the project director position in Section E.

- Additional staff and other resources dedicated to administrative and fiscal management activities of the grant and their relevant experience.

Section B: Implementation Plan (100 points; limited to 20 pages)

Applicants are expected to propose a project to effectively implement a school-based mental health promotion project **Reviewers will award points on the basis of the adequacy of the proposed project in addressing the criteria in each of the following sections.**

(1) Approach to Mental Health Promotion in the School and Goals of the Project (15 Points)

Describe the scope of the school-based mental health project that will be developed. The proposed scope should take into account feasibility issues in implementing a comprehensive mental health approach in the school community (e.g., financing, stigmatization, support of key constituencies). The scope of mental health programs is discussed in Appendix B:

- Describe the the project's conception of promoting positive mental health, including the personal and interpersonal competencies/skills that will be promoted in the school setting.

- Describe the types of mental health problems that will be identified and addressed in the school-based mental health project.

State one or two major goals for the project in **each** of the following areas that would have a significant impact on promoting positive mental health in the school community:

- Acceptance by the school community of a mental health promotion approach.

- Implementation of mental health promotion/prevention programs or services for the whole school community.

- Identification and assessment of children/youth in the schools with mental health problems.

- Provision of treatment and psychosocial services to children with mental health problems in the schools.

Goals can be in stated in terms of individual student mental health strengths or problems adequately addressed, numbers and types of youth and/or families served, programs/services developed, or other goals demonstrating comprehensiveness and effectiveness of the mental health approach.

(2) Development and Expansion of School-based Mental Health Programs (40 Points)

School-based Mental Health projects are expected to include the following components:

- Activities and programs to increase understanding of mental health issues in the school setting and support for the mental health promotion approach developed for the school(s). These activities and programs would be targeted at all the constituencies in the school community and could include in-school and community information and psycho-educational campaigns, school-wide forums, and curricula on mental health issues.

- Mental health prevention and promotion activities and programs, including activities and programs targeted to the general school population to enhance healthy social, emotional, and psychological functioning that reduce risk factors and enhance protective factors for mental health problems. Such programs could include activities or programs promoting positive and effective peer interactions, social skills, stress reduction, coping processes, tolerance and anti-bullying attitudes, teacher-student relationships, discipline procedures, and family involvement in schools.

- Identification/assessment of students with mental health problems, or at risk for mental health problems, particularly under-recognized problems, such as depression, suicidality, anxiety, and trauma. These procedures could include such approaches as teacher referral, self or peer referral, screening, or evaluation by school student services staff or mental health professionals. Procedures should be in place to provide in-depth assessment of students identified as showing evidence of or being at risk for mental health problems for purposes of intervention planning.

- Mental health treatment and psychosocial services interventions for identified student mental health problems. An array of effective mental health treatment programs and psychosocial services should be developed and made available to students in the school setting or by referral to out-of-school service providers. These intervention programs can include, for example: (1) standardized treatment programs for child mental health problems, such as manualized treatment programs for depression, anxiety, and anger and aggression problems; (2) well-specified multimodal treatment and psychosocial support programs for children, parents, and families; (3) case management and wraparound service approaches; (4) monitored psychopharmacological interventions; and (5) referrals for treatment at specialized clinics or in more intense therapeutic milieus, such as residential treatment programs, partial hospitalization, or brief hospitalization.

For each of the above project components, describe:

- Programs/services/activities that currently exist in the school or are available to students.

- The adequacy of existing programs, or the need for program/services/activities in the area.

- Major types of programs/services/
  activities to be developed, including identification of specific programs considered for implementation.

- Summary of rationale for programs/services/activities selected. Applicants should discuss any evidence that the proposed intervention programs and services demonstrate effectiveness in ameliorating mental health problems in children and adolescents in the form of: (1) published evaluations or research on proposed programs or the underlying conceptualization of the program, (2) evidence for consensus of the effectiveness of an intervention approach among clinical specialists or service providers, or (3) documented outcome effectiveness of the intervention approach in local implementation of an intervention approach.

- Additional training, contracting, or consultation needed to implement
  programs/services/activities in these areas.

(3) Project Evaluation (15 Points)

The primary purpose of the evaluation of the school-based mental health project is to gather information which will be useful to the project staff in monitoring progress of the project, assessing success of the project components, informing decision making by project staff, and communicating results to the school community.

Projects must budget at least 10 percent of the total budget for evaluation activities (*unless the school system has a qualified evaluation staff and contributes its evaluation effort as an in-kind contribution; in that case, the application must clearly indicate this*).

The project is required to have an evaluator or an evaluation staff that is qualified by training and experience to conduct an adequate evaluation of the progress of the project and the outcomes of expanding or enhancing school-based mental health programs and activities.

Provide a preliminary list of specific indicators of progress or outcomes and/or a plan specifying the methodology that will be used to gather information about progress and outcomes for each of the following components of the school-based mental health project:

- Support among groups in the school community for a comprehensive, school-wide mental health approach.

- Impact on the general school population of the preventive/mental health promotion programs.

- Success in identification/assessment of students with mental health problems in the school population.

- Outcomes of mental health treatment/services provided to students identified with mental health problems.

Describe how project staff will use evaluation results in monitoring project progress and planning activities and programs and how evaluation results will be fed back to the school community.

Describe the qualifications and experience of the project's evaluation staff to conduct the evaluation of the progress and outcomes of the school mental health project.

- If an Evaluator has not yet been selected, a position description listing the minimum qualification and experience requirements should be attached in Section I.

- Indicate additional expert consultation on evaluation design, instrumentation, data gathering, and analysis that will be contracted as part of the evaluation of the project.

Describe involvement of school community constituencies, especially teachers, youth and families, in developing and implementing the evaluation plan.

Describe plans to ensure that the evaluation plan and procedures are culturally and socially appropriate, such as being acceptable to members of cultural and social groups in the target population and being appropriate indicators for the diverse groups in the target population.

(4) Plan for Sustainability (15 Points)

Resources that can be developed to support the continuance of school-based mental health programs include: (1) human resources (e.g., dedicated staff, expertise and training of service providers, school and community support); (2) financing (e.g., school system budget support, grant support, service reimbursement); and (3) other resources (e.g., governmental or school system mandates, working relationships with outside providers, volunteer or donated services or materials).

Describe or document the available significant human, financing, and other resources for sustaining school-based mental health programs.

Describe a plan for developing enhanced sustainability of school-based mental health programs, including plans to:

- Systematically collect information on available or accessible human, funding, and other resources.

- Recruit additional school or other resources to support sustainability of school mental health programs.

(5) Competence with Respect to Community Diversity (15 Points)

School-based Mental Health projects are expected to:

- Have representation by major ethnic/cultural/social groups in the school community in the planning and implementation of school-based mental health services.

- Initiate efforts to increase the competence of the school mental health staff in responding to the ethnic/cultural/social diversity of the school(s).

- Increase the competence of the school staff and the service providers in addressing cultural and other types of diversity in the community by increasing awareness of issues of diversity among students.

- Monitor the accessibility and competence of services dedicated to or open to the major population groups in the school(s).

- Monitor the effectiveness of mental health programs with respect to the different ethnic/cultural/social groups in the school(s).

Describe the accomplishments of the school(s) or school system in addressing diversity in the school community, including:

- The extent to which school and mental health staff reflect the ethnic/cultural/social diversity of the target service population.

- The major methods used to ensure participation of the diverse ethnic/cultural/social groups in school mental health promotion and in selection and implementation of school-based mental health services.

- Language translation and community communications practices for contacting student and families in the major non-English languages of the community.

- The extent to which service providers are proficient in the languages and cultures of the major student groups in the school.

- Training in cultural and other types of diversity that the school(s) or school system has sponsored or participated in.

Describe plans to expand the competence of the school-based mental health programs with respect to cultural and other forms of diversity, including plans to:

- Increase participation of diverse ethnic/cultural/social groups in the planning, implementing, and evaluating of specific mental health programs or approaches in the school community.

- Increase the competence of school and service provider staff with respect to cultural and other types of diversity.

- Recruit or train representatives of minority communities to provide leadership for mental health promotion within their communities.

Confidentiality and SAMHSA Participant Protections (SPP)

You must address seven areas regarding confidentiality and SAMHSA participant protection in your supporting documentation. However, no points will be assigned to this section.

This information will:

- Reveal if the protection of participants is adequate or if more protection is needed.
- Be considered when making funding decisions.

Some projects may expose people to risks in many different ways. In Section I of your application, you will need to:

- Report any possible risks for people in your project.
- State how you plan to protect them from those risks.
- Discuss how each type of risk will be dealt with, or why it does not apply to the project.

The following seven issues must be discussed:

Protection of Clients and Staff from Potential Risks:

- Identify and describe any foreseeable physical, medical, psychological, social, legal, or other risks or adverse effects.

- Discuss risks which are due either to participation in the project itself, or to the evaluation activities.

- Describe the procedures that will be followed to minimize effects of or protect participants against potential health or confidentiality risks. Make sure to list potential risks in addition to any confidentiality issues.

- Give plans to provide help, if needed, if there are adverse effects on participants.

- Describe alternative treatments and procedures that might be beneficial to the subjects where appropriate.

- Offer reasons if you do not use other beneficial treatments.

Ù Fair Selection of Participants:

- Describe the target population(s) for the proposed project. Include age, gender, and racial/ethnic background. Address other important factors, such as homeless youth, foster children, children of substance abusers, pregnant women, or other special population groups.

- Explain the reasons for using special types of participants, such as pregnant women, children, institutionalized or mentally disabled persons, prisoners, or persons likely to be vulnerable to HIV/AIDS.

- Explain the reasons for including or excluding participants.

- Explain how you will recruit and select participants. Identify who will select participants.

Ú Absence of Coercion:

- Explain if participation in the project is voluntary or required. Identify possible reasons why it is required (e.g., court orders requiring people to participate in a program).

- State how participants will be awarded money or gifts, if you plan to pay them.

- State how volunteer participants will be told that they may receive services and incentives, even if they do not complete the study.

Û Data Collection:

- Identify from whom you will collect data (e.g., participants themselves, family members, teachers, and others. Explain how you will collect data and list the site. For example, will you use school records, interviews, psychological assessments, observation, questionnaires, or other sources?

- Identify what, if any, type of specimen (e.g., urine, blood) will be used. State if the material will be used just for evaluation and research or for other uses. Also, if needed, describe how the material will be monitored to ensure the safety of participants.

- Provide in Appendix 3 copies of all available data collection instruments and interview protocols that you plan to use.

Ü Privacy and Confidentiality:

- Explain how you will ensure privacy and confidentiality. Include who will collect data and how it will be collected.
- Describe:
  -How you will use data collection instruments.
  - Where data will be stored.
  - Who will or will not have access to information.
  - How the identity of participants will be kept private (e.g., by using a coding system on data records, limiting access to records, or storing identifiers separately from data).

NOTE: If applicable, grantees must agree to maintain the confidentiality of alcohol and drug abuse client records, according to the provisions of Title 42 of the Code of Federal Regulations, Part II.

Ý Adequate Consent Procedures:

- List what information will be given to people who participate in the project. Include the type and purpose of their participation. Include how the data will be used and how you will keep the data private.

- State:
  -Whether their participation is voluntary.
  -Their right to leave the project at any time without problems.
  - Risks from the project.
  - Plans to protect clients from these risks.

- Explain how you will get consent for youth, the elderly, people with limited reading skills, and people who do not use English as their first language.

  Note: If the project poses potential physical, medical, psychological, legal, social, or other risks, you should get written, informed consent.

- Indicate if you will get informed consent from participants or from their parents or legal guardians. Describe how the consent will be documented. For example: Will you read the consent forms? Will you ask prospective participants questions to be sure they understand the forms? Will you give them copies of what they sign?

- Include sample consent forms in your Appendix 3. If needed, provide English translations.

Note: Never imply that the participant waives or appears to waive any legal rights, may not end involvement with the project, or may release your project or its agents from liability for negligence.

Describe whether separate consents will be obtained for different stages or parts of the project. For example, will they be needed for both the treatment intervention and for the collection of data? Will individuals who do not consent to having individually identifiable data collected for evaluation purposes be allowed to participate in the project?

- Risk/Benefit Discussion:

- Discuss why the risks are reasonable when compared with expected benefits and importance of the knowledge from the project.

APPENDIX A

DESCRIPTION OF THE RATIONALE, GOALS, AND DESIGN OF THE YOUTH VIOLENCE PREVENTION COOPERATIVE AGREEMENT GRANT PROGRAM

A set of supportive documents is available for this GFA. These documents are available either in the application packet from the CMHS Knowledge Exchange Network or by downloading them from the SAMHSA web site at www.samhsa.gov/grants/. Click on the link to Currently Available Grant Opportunities, FY 2001. Documents include a: (1) list of references and resources on youth violence prevention/youth development programs, collaboration, service program implementation, and evaluation; (2) background paper on the CMHS youth violence prevention initiative; and (3) publication on cultural competence standards.

Background and Rationale for the Design of the Youth Violence Prevention Cooperative Agreement Grant Program

Rationale. The need for an initiative to provide communities with opportunities to implement programs to effectively reduce youth violence, substance abuse, and other risky and negative behaviors; to prevent suicide; and to promote positive youth development is driven by the prevalence of such problem behaviors among youth and the resulting negative, and sometimes devastating, effects on youth, their families, and communities, especially with the more severe forms of such problem behaviors. Multiple victim school shootings drew national attention to the problem of youth violence and Federal, State, and local efforts to reduce the risk for youth violent acts.

Youth violence can take many forms, including: *peer aggression*, such as fighting and more serious forms of peer violence, gang violence, bullying, harassment, and other forms of aggression in schools (often against younger and/or vulnerable youth, such as physically handicapped, developmentally delayed, or gay and lesbian youth); *violence against family members*, such as parents or siblings; *dating violence*; and the self-directed violence of *suicide and suicide attempts.* Violent crimes committed by adolescents have increased. The homicide rate has increased to such an extent that homicide and suicide are now among the leading causes of death among children and adolescents – with racial/ethnic minority youth at a markedly increased risk for violent deaths. Youth's perception of their lack of safety in schools and the community has increased as well. A significant percentage of students report fear of being attacked or harmed at school or report the presence of gangs in their schools. Violence and the fear of violence in schools and communities interfere with normal learning and arrest or delay the successful completion of normal developmental tasks of vulnerable children and youth.

Violent victimization, serious substance abuse, and completed or attempted suicide can have serious, long-term, and even detrimental, lethal effects on youth development and mental and physical well-being. For summaries of available documentation and statistics on youth violence, suicide, and substance abuse, consult the following resources: Juvenile Offenders and Victims: 1999 National

Report and Annual Reports on School Safety (available at http://ojjdp.ncjrs.org/pubs/violvictsum.htm): the Surgeon's General's Report on Youth Violence (available at www.surgeongeneral.gov/library/youthviolence) the Surgeon General's National Youth Suicide Prevention Strategy (available at www.surgeongeneral.gov/library/calltoaction/strategyintro.htm); Summary of Findings from the 1998 National Household Survey on Drug Abuse (available at www.samhsa.gov/centers/csat/csat.html); and Youth Risk Behavior Surveillance-United States (available at www.cdc.gov/nccdphp/dash/yrbs/index.htm).

Knowledge Base on Youth Violence. There exists a considerable scientific knowledge base regarding risk and protective factors for youth violence, suicide, and other problem behaviors and the fostering of resilience and the prevention of violence. This body of research has important implications for the design of preventive intervention approaches for reducing risks for problem behaviors among youth. Practitioners and researchers in the field of prevention have begun to use this knowledge base to design intervention approaches and programs that decrease risk factors for violence, antisocial behaviors, and other adolescent problem behaviors and/or increase protective processes. Research findings that have implications for the development and implementation of violence prevention approaches and programs include the following:

- Preventive interventions should be guided by knowledge of how multiple risk and protective factors interrelate and are causally linked to future violence and of how and when they should be addressed through intervention. Violent behavior results from an individual's personal characteristics, dispositions, and past history interacting with characteristics of the social environment. Risk factors include *individual factors*, such as a history of aggressive, antisocial, and impulsive behavior and mental health problems; *interpersonal factors*, such as peer support for antisocial behavior; *family factors*, such as lack of parental supervision, family violence, and family support of antisocial attitudes and behavior; *school factors*, such as poor achievement and low commitment to school; and *neighborhood and community factors*, such as poverty and prevalence of criminal behaviors. Risk factors for suicidal behaviors (thoughts, threats, attempts) include depression and other mood disorders, impulsivity, drug and alcohol use, and family problems. Protective factors that decrease the likelihood of engaging in violence and other problem behaviors include individual factors, such as positive coping with peer pressure and prosocial attitudes; interpersonal factors, such as positive attachment to prosocial peers and adults; and social factors, such as family, school, and community attitudes supporting positive prosocial behaviors and being intolerant of violence and antisocial behavior. One of the strongest findings in risk factor research is that the risk for problem behaviors tends to escalate with the number of risk factors evidenced by youth, and, similarly, risk decreases significantly with the number of protective factors. Moreover, high-risk youth can be identified by the severity of potent risk factors and/or the number of risk factors exhibited.

- Although effective interventions have been developed that target many risk and/or protective factors, most interventions have relatively modest effects, demonstrate a significant effect with only some intervention recipients, and often do not have long-term effects or carryover to later developmental stages. These results imply that no one intervention program is likely to have a

dramatic effect on reducing youth problem behavior. In order to significantly reduce youth violence and other problem behaviors, a variety of effective interventions needs to be developed and made available to target multiple risk and protective factors (e.g., youth attitudes and social behavior, parental monitoring, and family communication and interaction) in multiple settings (e.g., home, school, and community) at various ages (e.g., from early home visitation programs for infants to afterschool recreational programs for adolescents) at various levels of individual and psychosocial risk (e.g., from school-based universal substance abuse prevention programs to diversion programs for arrested delinquents).

- The type and potency of risk factors vary with age. For example, early familial child abuse is a potent risk factor for early aggressive behavior; association with antisocial peers is a potent risk factor in mid-adolescence; and lack of economic opportunity and job skills is a strong risk factor in late adolescence. Moreover, involvement in violent and antisocial behavior follows a developmental pattern in which early family conflict and neglect lead to early child aggressive and oppositional behavior followed by school and peer difficulties followed by early adolescent antisocial and substance abusing behavior followed by association with antisocial peers and an escalation in antisocial and aggressive behavior in adolescence and early adulthood. Early age of onset is a particularly potent risk factor for later serious and chronic problem behaviors. Violent behaviors often progress in seriousness, as offenders tend to add more serious offenses to their behavioral repertoire over time. Therefore, early interventions that disrupt or delay the development of serious aggressive and antisocial behavior may be a particularly valuable long-term intervention approach. Possibly because of the greater malleability of behavior at early ages before problem behaviors have been deeply ingrained, some of the strongest intervention effects have been shown by early preventive intervention programs. Preventive interventions across the entire age range, including prior to the emergence of aggressive and antisocial behaviors, are supported under this program as a viable and important approach to ultimately reducing youth violence.

- Problem behaviors, such as violence and substance abuse, often co-occur, as do risk factors, such as neighborhood poverty and peer support for antisocial behavior. Similar risk factors tend to be associated with different forms of problem behaviors. Therefore, interventions that effectively reduce risk for one type of problem behavior may also reduce other types of problems behaviors. Often, effective interventions for problem behavior reinforce individual psychosocial competence and prosocial behaviors that compete with the problem behaviors.

- Prevalence and severity of youth problem behaviors and risk and protective factors vary across social-environmental contexts. For example, alcohol, drug abuse, and school bullying and harassment might be characteristic of a higher income community and associated with peer attitudes and adolescent risk taking behavior; whereas, gang violence and dropping out of school might be characteristic of a socially and economically disadvantaged community and associated with inadequate schools, low student commitment to school achievement, and student truacy, suspension, and expulsions. Priority funding consideration will be given in this program to applications that can demonstrate high prevalence and/or seriousness of youth problems, risk factors, and service need.

- Socioenvironmental risk factors, such as poverty, lack of economic opportunity, and prevalence of crime and social disorganization, are particularly characteristic of some communities with large ethnic minority populations. Thus, some ethnic minority youth experience high rates of problem behaviors and risk factors. African American youth are arrested for juvenile offenses at twice the rate of the percentage in the youth population and at three times the rate for violent offenses, and they are incarcerated at three times their population rate. Young African American females; are *four times* more likely to die by homicide than are non-African American females; whereas young African American males are *eleven times* more likely to die by homicide than are non-African American males. Significant percentages of Hispanic boys and girls report assaulting another person in the past year and belonging to a gang. Hispanic adolescent girls have much higher rates of depression, substance abuse, suicidal ideation, and suicide attempts than do adolescents in general. Native American youth have equal or significantly higher rates of developmental and mental health problems, suicide, substance abuse, delinquency, and dropping out of school as compared to adolescents as a whole and experience high rates of poverty, lack of economic opportunity, low educational achievement, social isolation in rural reservations, or residence in low-income urban areas. Immigrant and refugee ethnic minority youth may also experience stress from war-related trauma, forced evacuations or escapes, acculturation, and intergenerational conflict resulting from differing levels of acculturation in the family. Recent refugees/immigrants may experience dramatically high rates of poverty and constantly face language, health/mental health, educational, and political disadvantages, as well as acculturation stress, exploitation, and discrimination. Consequently, available data indicate increasing rates of problem behaviors in Asian American/Pacific Islander youth, such as substance abuse and mental health problems, gang membership, and arrests for violent crimes. On the other hand, major protective factors in many minority groups are the values of communalism, family-centeredness, and group harmony, which deter violent behaviors by increasing the youth's social supports both inside and outside the family. In addition, positive appreciation by bicultural youth of their family's cultural heritage can also serve as a protective factor. Lack of available culturally competent intervention services contribute to a lack of youth services for racial/ethnic minority youth. To effectively provide services to high-risk and underserved ethnic, cultural, and social minority youth and their families, service providers must respectfully engage such youth and families and include them in all aspects of service planning, and provide services that are responsive to their backgrounds and cultural experiences.

- Some groups of youth share characteristics or life experiences which make them especially vulnerable to hostility and violent victimization, due to their differences from the majority of the population. Such groups include youth with physical disabilities or developmental delays; gay, lesbian, and bisexual youth; recent immigrant and refugee youth; and youth in out-of-home residence, such as those who are homeless, or living in shelters, foster care, and residential or detention centers. Such groups may have limited personal and social resources to be assertive and to protect themselves from violence, and they may experience significant prejudice, discrimination, harrassment, bullying, and other forms of victimization. There may be few dedicated service programs for these groups and a lack of knowledge of or reluctance to engage existing youth services. These high-risk and underserved groups should also be a priority for community approaches to youth violence prevention.

Program Goals and Design

The goals of the Youth Violence Prevention Cooperative Agreement grant program are to:

- Support the development (Youth Violence Prevention for Vulnerable Youth Projects) or expansion of collaboration among community organizations and constituencies to sponsor and/or promote community activities and services that facilitate the development in young people of the personal and interpersonal skills and emotional resilience necessary for healthy development and engagement in prosocial behaviors and to prevent violence, suicide, alcohol and substance abuse, and other youth problems.

- Support the selection and implementation of collaboration activities and service programs to address youth violence prevention, suicide prevention, and resilience enhancement that are effective in the community.

- Encourage and support evaluation of the collaboration process and the effectiveness of collaborative activities and youth service programs that will be useful in improving the collaboration, building community support, and providing effective youth services and that will provide information to the Federal government and other communities about the processes and outcomes of community collaboration and implementation of effective programs to prevent youth violence and enhance youth resilience.

- Support efforts of youth violence prevention community collaborations to develop resources to sustain the community collaboration, its activities, and youth service programs in the community.

- Support development of increased competence of youth violence prevention collaborations in understanding, engaging, and providing effective services to the diverse racial, ethnic, cultural, and social groups in the target community population in order to more effectively address youth problems and youth development in the community.

Community Collaboration

Rationale. Community collaboration is viewed as an effective strategy for health promotion and preventive services in community settings. Community collaborations are cooperative endeavors of major community organizations, service systems, and representatives of stakeholder constituencies to address community problems or promote community development. Collaborations usually have a structure, administrative staff or support, goals, operational procedures, and planned set of activities that are agreed upon by the collaboration participants. Community collaborations are defined by the participation of community stakeholders. Critical community stakeholders for youth violence prevention collaborations are defined as those individuals, organizations, and constituencies with a significant stake in youth violence prevention and youth development and who have the authority and/or resources to initiate, develop, implement, support and/or evaluate collaborative activities and service programs that address youth violence and youth development. Such stakeholders might include: (1) representatives of

community constituencies that will receive, provide, or support youth and family services, including youth; families; existing youth service providers in education, mental health, juvenile justice, and family services; faith leaders; cultural brokers; advocates; and community leaders; and (2) key decision makers in the community able to make funding or resource commitments to support implementation and sustainability of collaboration activities and youth services, such as political leaders, agency heads, foundation staff, and business leaders. In particular, CMHS requires active inclusion of client constituents (i.e., youth and their families) in all phases of collaboration and service provision that affect them.

Community collaborations have a number of advantages as an approach to community problem solving including: (1) the ability to facilitate coordination of multiple resources and services, (2) a means for participation and input from the important constituencies in the community who have an interest in the community problem, (3) the ability to recruit existing resources and develop new resources to address the community issue, and (4) a higher likelihood of gaining community acceptance of and support for sustaining services targeted to the community issue. The Youth Violence Prevention Cooperative supports development of community collaboration as the strategic approach to youth violence prevention and youth development.

Forms of Collaboration. A single form of collaboration is not feasible nor optimal in every community. Collaborations can vary in size or inclusiveness and in degree of collaboration achieved. Collaborations vary in size from partnerships between service organizations or systems (e.g., a partnership between a school system and mental health agency for suicide prevention activities) to coalitions of the primary service providers and governmental agencies in a community to large, community-wide collaborations involving most of the primary organizational and stakeholder constituencies in the community. A number of factors can determine the size and inclusiveness of collaborations, including the history of collaborative activities in the community, external pressure or support for collaborative activity, and willingness of significant organizations and constituencies to engage in collaborative activities. Larger, more inclusive collaborations are preferable, but often it is not feasible to recruit participation of all stakeholders, often because of their unwillingness to commit to collaborative activities. In addition, large collaborations can sometimes become unwieldy. The degree of collaboration achieved can vary from sharing of information to coordination of activities to commitment to shared goals, planning, resources, and decision making. The Youth Violence Prevention Cooperative Agreement program allows a range of sizes and degrees of collaboration in projects.

Youth Violence Prevention Cooperative Agreement grant projects may develop a collaboration for either geographically- or socially-defined communities. Geographic communities are usually based on natural, historic, neighborhood-identity, or institutional (e.g., a specific school or school system) boundaries. Socially-defined communities are groups characterized by social identities, such as ethnicity (e.g., Hispanic youth), culture (Dominican), religion (e.g., Muslim youth), common experience (e.g., incarcerated youth), or other type of social identity (e.g., gay and lesbian youth). Geographically-defined collaborations should, ideally, encourage access to collaborative activities and support services for the entire youth population of the area. There may be a justification for a focus on only subgroups of the youth in the geographical area, rather than inclusion of all youth groups in the community in

collaboration activities and access to services. For example a collaboration might target a socially-defined population (e.g., Southeast Asian refugee youth) for youth violence prevention/youth development services, due to unique risks or problems (e.g., cultural differences, social and geographic segregation, language barriers, and participation in ethnic gangs) and inadequate services (e.g., high need and lack of culturally competent services).

Collaboration Activities. Collaborations can engage in the following types of activities: (1) collecting data on youth problems and risk factors in the community and on the availability and adequacy of existing community resources and services; (2) educating the community about youth problems, service needs, and strategic approaches to violence prevention and positive youth development; (3) mobilizing community attention and support for violence prevention/youth development activities and programs and providing a voice for consumer constituencies in collaboration and service delivery; (4) achieving consensus among community organizations and constituencies on youth problems that need to be addressed and approaches to providing services targeting identified youth problems; (5) evaluating the effectiveness of collaborative activities; (6) selecting and implementing effective preventive services in the community; (7) evaluating the effectiveness of implemented youth services; (8) developing resources for sustaining collaboration and services; and (9) increasing the competence of collaboration participants and service providers in addressing violence prevention and youth development among the diverse youth and families in the community.

Effective Collaboration and Youth Violence Prevention/Youth Development Services

Procedures to Improve Effectiveness of Collaboration. In order to have a significant overall impact on youth problems and youth development in the community, collaborations must engage in a set of planned activities to build the collaboration, to engage the community in violence prevention/youth development, and to develop needed youth and family services. To conduct these activities effectively, the collaboration should develop a set of procedures to: (1) collect information that would be useful in planning collaboration activities and in addressing youth service needs, (2) monitor collaboration development and the impact of collaboration activities, (3) develop evaluation criteria and procedures and the capacity and expertise to evaluate the likely success of the proposed service programs, (4) assess results achieved by collaboration activities and service programs, and (5) incorporate this assessment into the collaboration decision making process. Supporting the development of procedures and the capacity of collaboratives to improve the effectiveness of collaboration functioning and service programs is a goal of the Youth Violence Prevention Cooperative Agreement program.

Information Collection Procedures. Information that would be useful to obtain or collect for planning collaboration activities and addressing youth service needs includes: (1) demographic and social environmental characteristics of the community; (2) prevalence and distribution of youth problems, risks, and strengths; (3) existing youth services, their availability, and effectiveness; and (4) needed youth services, capacity of the community's service system to implement the services, and their likely effectiveness with the community's youth. Unless the collaboration has the capacity to collect or assemble such information, summarize this information in an understandable form (e.g., reports,

presentations, work group reports, data bank), and use this information in collaboration decision making, it will largely be making decisions in the dark as to the problems and service needs of community youth, the effectiveness of existing services, and the activities and services implemented by the collaboration.

Monitoring Procedures. Monitoring the collaboration process and activities for success in achieving the goals of the collaborative can improve functioning of the collaboration. Demonstration of collaboration success can reinforce participation in the collaboration and build community support. This is especially true in the initial stages of collaboration development. Monitoring of the collaboration process usually includes assessment of the degree of participation, commitment, and satisfaction of collaboration partners, an objective assessment of barriers to and/or difficulties in collaborating, and the number of activities sponsored by the collaboration, their success in achieving the goals of the collaboration, and their impact on the youth in the community and on the community as a whole. Activities that community collaborations can engage in and that should be monitored for effectiveness include: (1) activities that enhance collaboration, such as identification and engagement of potential collaboration participants, administration of the collaboration, planning and goal setting activities, and building commitment and consensus among collaboration participants; (2) data collection, assessment, and evaluation activities, such as assessing youth problems and community resources and evaluating effectiveness of implemented programs; (3) communication and dissemination activities, such as a media campaigns, newsletters, or other communications with community groups; and (4) activities to recruit or develop resources to improve collaboration, implement services, or sustain activities and service programs. The Youth Violence Prevention Cooperative Agreement program requires evaluation of the collaboration process and outcomes. This evaluation information, together with other information, can be used as part of the collaboration monitoring process.

Procedures to Evaluate Services. A particularly important activity of youth violence prevention community collaborations in addressing youth problems and risks in the community is to assess the adequacy of available services and then to either support or enhance existing services, or develop additional services that will reduce youth problems and risk. Collaboratives can, but need not, directly implement service programs. Collaboratives can endorse or support the expansion of existing services, recruit service providers to implement needed services, implement needed services through participant service providers, or implement service programs directly as a collaboration function. Given a collaboration consensus on the need for a particular kind of youth service, decisions on selection of specific programs to support, expand, or implement to meet the service need should be based on the best available evidence of the likelihood that such programs will achieve their intended effects in changing targeted youth problems and risks. For example, if there is a collaboration consensus that poor school achievement is a potent risk factor in the community target population, specific programs that are targeted at raising school achievement should be evaluated as to their likely success in raising school achievement among youth in the target population. There exists a considerable number of programs that have been developed targeting youth problems or risk or promoting capacity for healthy youth development that could address the priorities of youth violence prevention collaborations and that have some evidence of effectiveness in changing their intervention targets. Adoption of existing evidenced-based programs would likely be preferable to locally developing new programs that do not

have documented effectiveness, except when there are well-developed local programs with demonstrated effectiveness with the specific target population in the community. Collabortives should develop a set of criteria and procedures to evaluate the adequacy of existing services and the kinds of services that need to be developed to have a significant impact on reducing youth risk or problem behaviors in the community; they should also be likely to recruit community and funding support. The Youth Violence Prevention grant program provides support for projects to develop procedures and the capacity to evaluate the effectiveness of existing service programs as well as the likely effectiveness of new programs considered for implementation to meet service needs. These procedures should be used in collaboration decision making about programs to support, expand, or select for implementation.

Considerations in Evaluating Services. Some considerations in evaluating the adequacy and need for services include: (1) Services should target the most prevalent and/or most serious problems or risks among youth for which adequate programs do not already exist in the community. (2) Services selected for implementation in the community should address the priority needs of youth as perceived by the community and for which consensus on the need for services exists or can be achieved. For example, although a lead agency in a collaboration might propose implementing a family services center in the community, there may be more concern in the community about after-school idleness and school failure among community youth and a consensus in the community that after-school recreation/homework programs and stay-in-school programs are a higher service priority for youth in the community than a family services center. (3) Collaborations should reach consensus on the level of risk that would be the main focus of intervention services. Universal preventive interventions that target all or most youth in the community usually require less staff training, are less intense in terms of client time and effort, can reach large numbers of youth in the community, and may be more effective in mobilizing community support for violence prevention than programs targeting high-risk youth. In contrast, interventions for high-risk youth (e.g., youth in the juvenile justice system) usually require higher levels of service provider training and skill, need more client time and effort, and reach only a select group of youth in the community, but may have a more dramatic impact on serious youth problems in the community, which are usually characteristic of a small minority of youth in the community. (4) Intervention programs should be selected with regard to the time line for the likely impact of the intervention on the community. Services that can provide immediate, short term impact will more likely motivate support in the community for collaboration activities. Services that can produce more significant long-term impact might be more successful in recruiting sources of funding to sustain the intervention.(5) Services should be selected for support or implementation that the service system in the community has the capacity to implement or can receive adequate training to implement. Such capacity may derive from existing dedicated service organizations (e.g., there may be community agencies that provide adolescent drug treatment). Alternatively, service providers might be trained to provide needed services, if adequate training is available and potential providers have the qualifications and background to effectively implement the intervention service.

Criteria for Likely Effectiveness of Service Programs. Evaluation of the effectiveness of programs should not be a one-time decision, but rather the result of an ongoing process of evaluating a number of effectiveness factors, including the demonstrated *potency* of the intervention program in effecting change in the intervention target, the *replicability* of the program, and the *adaptability* of the program

to the community target population. In evaluating the effectiveness of service programs, available evidence of the potency of an intervention may be reported in several ways, including: (1) the average amount of change in relevant outcomes achieved by the program, especially across implementation at different sites; (2) the percentage of program clients who complete the program and experience a significant impact as a result of receiving the intervention program; (3) the impact that change achieved by the program has on youth problems or development (e.g., a psychoeducational program might have large effects in changing youth's attitudes about risks of substance abuse, but such cognitive changes may not significantly counteract peer pressure, and, thus, significantly reduce youth substance abuse); and (4) how long it takes for the intervention to show significant positive outcomes and whether change effected by the program is maintained over time. Confidence in the likely effectiveness of an intervention program depends on the strength of the available evidence of the program's effectiveness. The strongest evidence of likely program effectiveness comes from published evaluation studies that report relevant client outcome measures, particularly those that document superior outcomes for participants in intervention as compared to nonintervention (control or alternative treatment) groups (e.g., a social cognitive enhancement intervention actually changes social cognitions). The strength of evidence of program effectiveness is also dependent on the number of evaluation studies showing positive outcomes and how well designed the evaluation studies were (e.g., Was random assignment to treatment conditions used? Was fidelity of treatment implementation assessed?). Other evidence of likely effectiveness can include strong empirical evidence that a not-yet-evaluated intervention program targets changeable risk/protective factors or mediating processes that are strongly related to targeted problems, using strategies that have been demonstrated as likely to alter the risk/protective and/or mediating factors (e.g., a suicide prevention program that targets depressive symptoms in adolescents at high risks for suicide). Other intervention programs may be candidates for implementation if they are model intervention programs designed by program developers with considerable expertise in youth violence prevention/resilience enhancement for which there is consensus among notable experts that the program might work to reduce youth violence and or youth suicide, and the programs have been replicated in a number of sites to provide some evidence of effectiveness based on client satisfaction data.

An intervention program is not likely to be effective in addressing youth problems if it is difficult for service providers in the community to implement it competently. Service programs are replicable to the extent that the program includes procedures to ensure that it can be implemented so as to maintain fidelity to the types and sequencing of intervention procedures in the original program design. Fidelity of program implementation is usually necessary to guarantee that an implemented program will achieve the same effects as the original program. Replicability may be increased by one or more of the following: (1) a clearly written and tested implementation manual that specifies the intervention goals and procedures; (2) training materials and activities to support program implementation (e.g., training courses or training videotapes); (3) availability of technical assistance on implementation from the program developers or from well-trained, experienced implementers; and/or (4) standardized measures of fidelity.

Evidence of the effectiveness of a service program may be based on evaluation of the program's outcomes on a target population that is significantly different (e.g., in terms of social class, the nature

and degree of problem behaviors or risk, ethnicity or culture, or the social environment) than the target population in the community. Confidence in the applicability of a service program to the community's targeted youth population is increased if: (1) the intervention has been shown to be effective in evaluations of the program in communities with different population characteristics or in communities with populations similar to the targeted youth population; and/or (2) distinct characteristics of service populations were identified that are likely to affect the administration or outcome of the intervention, and guidance is provided by the program developers on how to modify the program to accommodate these characteristics. Such characteristics might include age, gender, culture/acculturation, race/ethnicity, social class, and severity of problem behavior or risk. If appropriate, prevention/intervention programs should be adapted to the cultural or other characteristics of the target population. Such adapatations need to be implemented with careful consideration of the need to maintain fidelity to the goals and procedure of the original intervention, and the adaptations need to be carefully document and evaluated. Services should be selected that are within the capacity of the community to provide (e.g., agencies with the training or expertise to deliver different types of interventions), or for which adequate training is available, especially for a relatively large number of service providers. If programs are adopted that require intense, expensive training, especially at the program developer's site or a few associated sites, and a relatively high level of provider skill, there is a risk that the service will be significantly reduced or discontinued, if the trained staff leave.

Upon selecting service programs to support, expand, or implement, a necessary component of assessing the effectiveness of services is evaluating the actual implementation of the program in one's own community and the outcomes achieved. This assessment is of far greater importance than evidence that the program works in other communities. Evaluation of program implementation and outcomes is required in Youth Violence Prevention Cooperative Agreement projects.

Evaluation of Collaboration and Service Programs

Evaluation Goals. The evaluation component of the Youth Violence Prevention Cooperative Agreement program has three goals: (1) to monitor progress in developing community collaboration and provide useful feedback to collaboration participants and community constituencies for improving collaboration efforts; (2) to assess how well service programs are implemented and how effective they are in addressing youth problems in the community; and (3) to collect data on the experience of developing community collaborations and implementing youth services programs from all projects in the program, so as to inform the Federal government and other communities about effective approaches to and difficulties encountered in developing youth violence prevention collaborations.

The expectation is that the development of an evaluation plan, including collection of evaluation data, summarization or analysis of collected data, and reporting of results, will be a priority task of the collaboration. The evaluation plan and use of evaluation results should be developed by the collaboration participants, rather than assigned to evaluation experts. Consensus should be achieved among collaboration participants on the types of evaluation data that will be most useful for collaboration development, planning, decision making, service program selection and evaluation, and for achieving community and funding support. The Youth Violence Prevention Cooperative Agreement

grant program views this evaluation requirement as offering many advantages to youth violence prevention collaborations.

Qualifications of the Evaluator(s). The project should have an experienced evaluator or evaluation team working closely with other project staff, collaboration participants, and representatives of consumer constituencies, especially youth and their families, to develop and conduct the evaluation plan. The evaluator(s) must have advanced training in research or evaluation and must have considerable experience and expertise in evaluating community-based organizations and interventions in prior Federal grants or comparable projects, and the project should use this expertise to develop an evaluation plan that meets rigorous standards.

Evaluation Requirements. Four types of evaluations should be conducted in the project, and the results of these evaluations should be provided to the collaboration: (1) a description and documentation of the events, processes, achievements, and difficulties that occur during the collaboration/consensus development process; (2) the outcomes achieved by collaboration activities; (3) a description of the events, processes, success, and difficulties that occur in implementing youth service programs; and (4) the outcomes achieved by the implemented service programs. A plan for each type of evaluation involves identification of aspects of these processes or outcomes that are most important to assess, develop, or agree on indicators to use for assessment, identification or development of data collection methods, collection of the data, analysis of the collected data, and reporting of results. Objective, standardized evaluation instruments and procedures, if available, are preferred as indicators. Both quantitative and qualitative data can be collected, where appropriate. Usually multiple indicators (e.g., collected from multiple informants) are preferred. To the extent that it is feasible, quantitative evaluation measures or procedures should meet standards for reliability (e.g., inter-rater agreement of coding or ratings, test-retest stability), reliability across populations (e.g., adequate reliability with different age, gender, ethnic, cultural, and educational groups), validity (e.g., valid measurement of the key aspects of process or outcome), congruence between indicators of a measured construct (e.g., the same or a similar checklist given to different informants), and validity across populations (e.g., adequate validity in different age, gender, ethnic, cultural, and educational groups). Procedures that collect and analyze qualitative data should be well enough described so that results could be reproduced by other evaluators. Particular attention should be paid to making the evaluation measurement appropriate to the age, gender, ethnic, cultural, and social characteristics of individuals in the target population and acceptable to them. Evaluation experts and knowledgeable informants from the targeted communities, especially youth or family members who are to be assessed, should be engaged in developing or adapting measures.

Evaluation of the Collaboration Process. Evaluation of the process of collaboration/consensus development should include, at a minimum, a description and documentation and/or measurement of the events, processes, achievements, and difficulties encountered in: (1) identifying critical stakeholders (e.g., description of the use of existing collaborations, key informants, organizational registers) to participate in the collaboration; (2) engaging and maintaining the commitment of these critical stakeholders to the collaboration process (e.g., providing frequent and timely feedback to decision makers and other constituents on milestones achieved, use of expert facilitators, solicitation of Memos

of Understanding and formal Letters of Agreement, as well as difficulties encountered in achieving engagement or commitment); (3) administering the collaboration (e.g., description of the collaboration leadership and organizational structure, such as a lead agency, consensus development team, steering committee, topic-specific work groups); and (4) making and implementing key decisions (e.g., delegating or contracting of specific decisions, description of strategies used to resolve stalemates). Assessment instruments or methods used to describe and document the processes of collaboration and consensus decision making can include checklists, analyses of meeting process notes, analyses of administrative documents, or interviews of key informants with structured or semistructured interviews. Results of an evaluation of organizational development and group processes are typically presented as a qualitative analysis of the historical course of the collaboration, focusing on stages of key events, achievements, and problems that arise in the development of the collaboration. An evaluation of the collaboration process should also document changes in the structure or functions of the collaboration over time (e.g., new demands on the collaboration, changes in key personnel or in key stakeholders) and in the impact of external social-environmental factors on the collaboration (e.g., legislative and funding changes, community crises).

Evaluation of the Outcomes of Collaboration. Evaluation of the outcomes of the collaboration process and activities initiated by the collaboration can include success in: recruiting identified critical stakeholders to participate in the collaboration; developing an organizational structure and decision making procedures that allow planning, initiation, and completion of collaboration activities; achieving consensus on important decisions made by the collaboration; sponsoring or conducting activities and measuring the impact of such activities on community recognition, support, and mobilization to address youth problems and risks; and achieving stakeholder, collaboration staff, consumer, and community satisfaction with collaboration development and activities. Assessment procedures for outcomes of the collaboration and consensus development processes can include rating scales, questionnaires, official records, community surveys, or structured or semistructured interviews with key decision makers, participants, or constituents. (For example, indicators might include attendance at meetings, evidence of trust or cooperation among participants, agreement on mission or goals, or satisfaction of participants with the collaboration).

Evaluation of Program Implementation. Evaluation of the process of service program implementation should include an assessment of how and to what extent service programs are implemented congruent with the goals, structure, and procedures of the program as designed by the program developers (fidelity of program implementation); the procedures used to recruit and engage the target population in the program and to ensure completion of all components of the intervention; and the procedures used to ensure that the program implementer administers the intervention procedures in a manner likely to lead to successful client outcomes (implementer competence); and the extent to which consumers successfully complete the intervention components of the program (dosage). Assessments of the process of program implementation can include checklists of whether program goals and content (e.g., as specified in a program implementation manual) were followed during intervention sessions; completion by clients of assessment activities included in the intervention program that are indicative of completion of intervention procedures (e.g., activities that apply procedures learned in program modules in real world settings); records of the number of sessions attended and continuity of

attendance; records of the completion of assignments (e.g., homework assignments) during course of intervention; ratings of engagement of the client in the intervention process during sessions, either by the program implementer or by outside raters, from transcripts or tapes of sessions; interviews with clients regarding engagement in the intervention, satisfaction with the intervention procedures, and perceived benefits of the intervention; evidence that the client met the sequential goals specified in the program (e.g., in a sequence of goal-oriented modules described in the program implementation manual); client rating of satisfaction with the program and the intervenor; and ratings of characteristics of intervenor behavior during sessions (e.g., listening to client's comments, timing of intervention procedures, empathy and warmth), either by the intervenor following sessions, or by outside raters using transcripts or tapes.

Evaluation of Program Outcomes. Several different types of program outcome data could be collected. The most important outcome data would be measures that directly assess reductions in problem behaviors or increases in positive behaviors that are the ultimate targets of intervention programs (e.g., reductions in the frequency or severity of youth antisocial acts or improvements in school achievement). Some problem behaviors that might be the ultimate target of a prevention program occur with low enough frequency that it is difficult to show evidence of a real change in their rate of occurrence (e.g., suicides) and/or are difficult to measure. Thus, other indicators of program success (e.g., reduction in rates of depressive symptoms or in suicidal ideation) can be collected as proxy measures. Another appropriate class of outcome measures are measures of *satisfaction* with the intervention. Such data can be collected from youth, their families, their teachers, and program implementers. It is particularly important that the outcome measures chosen: (1) measure outcomes that the intervention is designed to impact; (2) are sensitive enough to measure changes in outcomes produced by the program; and (3) are appropriate for the characteristics of the target population, such as age, gender, ethnic and cultural background, and educational level of the program clients. Obtaining definitive program outcome data within the time frame for the project will be difficult. Applicants are expected to obtain only such outcome data as is feasible within this time frame. It is hoped that monitoring of outcome data will continue after termination of Federal funding, in order to evaluate the long-term impact of implemented service programs, and that such outcome evaluation would become institutionalized by community organizations as part of the process of implementing services in the community. Measures of program outcomes can include self-report measures; interviews of clients are also commonly used. Checklists and rating scales completed by parents, teachers, peers, or clinicians are also used. Behavioral observations in natural or analogue situations are sometimes collected, as are outcomes based on official data (e.g., crime rates, suicide rates, or school suspensions). In general, multiple measures (e.g., self-report inventories, observational measures, structured interviews) from multiple informants (e.g., youth, their parents, peers, teachers, and intervenors) are preferred to single-source measure assessment, if feasible.

Sustainability

Resources for Sustainability. Youth Violence Prevention Cooperative Agreement grant support is limited to 2 years, but efforts to significantly impact youth problems and promote positive youth development require a long-term commitment to coordinated community action. Hopefully, this effort

will be spearheaded over the long term by the youth violence prevention collaboration supported by this grant program, but to accomplish this requires developing the resources to sustain the collaboration, its activities, and youth service programs.

There are several kinds of resources that need to be developed to ensure sustainability of the collaboration and its activities, including human resources, funding sources, and other supportive resources. Human resources that can play a significant role in developing sustainability include: (1) time and energy that collaboration participants dedicate to collaboration functions and activities, (2) formal and informal cooperation established in the community resulting from collaborative activity (e.g., cooperation between school systems and mental health agencies), (3) community-wide recognition of youth problems and support for services to address youth, (4) volunteer time donated by individuals who live in the community to work on collaboration activities, (5) intervention skills acquired by service providers as a result of collaboration supported programs, and (6) grant writing capacity and other fund raising skills developed as a result of the project. Funding sources that can be accessed include: (1) community fund raising; (2) local, State, and Federal grant and contract support; (3) reimbursement from service system dollars; and (4) foundation and business support. Other supportive resources include: (1) administrative staff time, equipment, computer and other administrative services, and other material resource contributions donated by collaboration participants and/or community or outside sources; (2) legal and/or policy changes that facilitate or support community collaboration and/or youth services in the community; and (3) institutionalization of intervention programs into provider systems or other service system changes that support long-term service provision to youth in the community.

Sustainability is more likely to be achieved if it is recognized as an ongoing critical priority of the collaboration, and if resources are dedicated to efforts to achieve sustainability. The Youth Violence Prevention Cooperative Agreement program offers the advantage that budgetary resources can be dedicated to sustainability activities. Projects should engage in a specific plan of activities to recruit resources to sustain the collaboration and its associated activities and services and to dedicate collaboration resources (budget and staff) to sustainability efforts. Human and support resources developed or potentially developable as a result of the project should be inventoried and explicitly targeted for expansion or development as part of a project plan to sustain the collaboration, its activities, and services on a long-term basis.

Competence with Respect to Community Diversity

Diversity. Competent collaboration and service delivery must be sensitive and responsive to characteristics of youth and families in the target community to impact community participation in collaborative activities and effectiveness of service delivery. Such characteristics especially include racial/ethnic and cultural identity, but also involve gender; age; social identities, such as sexual orientation, gang membership, and acculturation status of immigrant populations; and characteristics related to geographic and economic environments, such as poverty, lack of economic opportunity, low literacy and educational achievement, and rural or other social isolation. Types and levels of risk factors and behavior problems can vary across racial, ethnic, cultural, and social groups of youth in the community. Even within minority populations, there is notable linguistic, cultural, and economic diversity.

Ethnic, racial, and cultural groups share many common characteristics that distinguish them from the majority social groups, but also show evidence of considerable heterogeneity. For example, there are over 500 Federally recognized American Indian tribes. Subgroup differences also intersect with other differences which exert a significant impact on the results of interventions, such as age and life experiences. Thus, adolescents across racial and ethnic groups may share a perspective, having values and behavioral patterns that are more similar than they are with adults in their own racial/ethnic group. Similarly, minority youth in gangs may be very different in their attitudes and behaviors than youth from the same minority group who do not belong to gangs. Youth violence collaboratives should promote collaboration efforts and youth service programs that are more adaptive to characteristics of the community's youth and families, as part of efforts to address youth problems and youth development in the community.

Some minority groups in the community might not have access to adequate culturally competent intervention services. Factors that might contribute to this relative neglect include the relatively large number and diversity of racial, ethnic, and cultural groups in the country and the relatively low population percentage of many of these groups; high rates of residence of minority groups in rural or low-income urban areas with few services; significant linguistic and cultural differences from the majority population; and lack of familiarity and underutilization of health, mental health, and social services. Because of the significant linguistic and cultural differences between these populations and the majority culture, cultural issues must be addressed when adapting existing youth service programs for these underserved at-risk populations. In addition, demographic and social environmental aspects of the community can impact how youth service programs are implemented, and how their results, such as the extent to which subpopulations (e.g., ethnic or cultural subgroups) are affected by different types of youth problem behaviors and require different types of services; the structure of influence in such communities, such as provided by leaders (e.g., elders, priests or ministers) or organizations (e.g., churches, clubs); and the availability of services and resources that are dedicated to the general population of youth and to the major subpopulations in the community and require language and cultural competence on the part of service providers.

Competence with Respect to Diversity. To be competent, the collaboration process, service programs selected for implementation, and the implementation process *must* attempt to take into account the values, norms, and life circumstances of the racial/ethnic, cultural, age, gender, and social groups that are being targeted for intervention. Projects that target specific ethnic/cultural groups or communities with substantial ethnic/cultural diversity must account for both common cultural and subcultural diversity in all phases of the project plan. Projects in communities with less ethnic/cultural diversity must nevertheless ensure that major ethnic/cultural groups in the community, especially underserved groups, have access to the proposed services and that such services are delivered in a culturally competent manner. Such an approach requires that adequate consideration be given to the following issues:

1. Project staff and collaborations must have sensitivity to and develop understanding of the ethnic, cultural, linguistic, and social demographics of youth in the community and develop an awareness of the

perspective on youth problems, positive youth development, and appropriate interventions by different community groups.

2. Participation of representatives of the major cultural and ethnic groups in the community in all phases of the collaboration and implementation process should be encouraged and facilitated. CMHS believes that consumer constituencies, such as children, youth, and families, must be appropriately involved in the conceptualization, planning, pilot implementation, and evaluation of SAMHSA projects. Outreach efforts should be made to obtain representation of youth, family members, and community leaders on all standing committees, steering committees, and advisory boards of the project. The collaborative should develop mechanisms to receive input and to provide feedback to community stakeholders and constituencies on the process and outcomes of the collaborative and implementation processes in a linguistic and culturally appropriate manner.

3. The collaboration and service programs should accomodate linguistic, cultural, and social differences in the population. Provisions should be made for full and equal participation for non-English-speaking or limited English-speaking youth and families in both collaboration efforts and receipt of services through language translation and interpreters. Project and service provider staffing should reflect racial, ethnic, and cultural diversity in the community and provide the project with the competence to implement the intervention with the major cultural groups in the target population. The key collaborating organizations' written policies, plans, practices, and training should reflect recognition of the diverse cultural values in the community.

Selection, implementation, and modification of service programs should take into account the acceptability of modes of intervention in major cultural groups in the community. Desirable service program outcomes should be solicited from the major cultural and social groups receiving the programs. Obtained outcomes should be acceptable to community groups and should be sensitive to stigmatization concerns (e.g., perceptions that some minority groups are highly antisocial). Information provided to or obtained from youth and families, including consent forms, surveys, outcome measures, and satisfaction surveys, should be available in languages and at reading levels understood by major cultural groups in the community.

4. Project staff and collaboration participants should monitor success and difficulties in developing greater community competence, including participation in collaboration and service planning and implementation by representatives of major racial, ethnic, cultural and social groups in the community, especially from subgroups receiving services; success of collaboration activities in engaging different subgroups in the community; recruitment, attendance, and dropout rates of different subgroups targeted for services; effectiveness of service programs across different major community subgroups; and linguistic and cultural appropriateness of information on collaboration, implementation, and program outcomes conveyed to major subgroups in the community.

Grant-supported Activities

Applicants should respond to the project requirements specified in the GFA. Below are some *examples* of particular activities that might be incorporated into a youth violence prevention project. The descriptions below do not represent requirements of the GFA, but provide material that may be helpful in responding to some of the requirements of the GFA. The application will be evaluated by a review committee solely on the basis of the requirements as stated in the GFA, not in this Appendix. The explanatory material in this Appendix is solely provided as possible examples of approaches that can be taken to the GFA requirements and may be helpful in developing parts of the application. The actual application should propose a response to the requirements of the GFA in keeping with the experience, capacities, and goals of the applicant organization and actual or potential collaboration participants.

The following are examples of potential activities to aid in developing collaboration or collaboration activities that may be supported by project funds:

- Providing staff and administrative expenses to support the collaboration organization.

- Covering logistic expenses of collaboration meetings and other forms of contact and collaboration activities.

- Providing expert consultation on developing collaboration or developing consensus among collaboration partners.

- Visiting or consulting with collaboratives in other communities.

- Recruiting collaboration participants or developing community support (e.g., supporting attendance at meetings).

- Obtaining input from and disseminating information to the community-at-large in support of collaboration and consensus building; facilitating the negotiation of agreements between or among agencies and/or service providers.

- Increasing awareness of the collaboration or mobilizing community support for the collaborative's initiatives through community-wide activities (e.g., media campaigns, special family and youth events) and monitoring the impact of collaboration activities.

- Disseminating newsletters or other communications to build community support and to publicize the impact of the programs on youth outcomes.

The following are examples of potential activities to aid in service program selection and implementation that may be supported by project funds:

- Gathering or accessing information on sociodemographic characteristics of the community, youth problems or risks, community attitudes and perceptions, and existing service resources or needs, such as surveys, community meetings, focus groups, census data, or official and service records.

- Obtaining expert consultation and training on assessment of youth, community attitudes, and resources.

- Assisting in the selection of youth, family, and community service programs to implement, such as collection and evaluation of published studies of the effectiveness of alternative service programs; visiting or consulting with organizations in other communities that are implementing service programs being considered for implementation in the community; providing training and/or expert consultation on identification and review of alternative evidenced-based youth service programs and on procedures to adapt programs to the community.

- Supporting costs of: service program implementation in the second phase of the project, such as training of service providers; expert consultation on implementing specific programs; program materials and assessment instruments; direct services, such as provider time; and outreach to or recruitment of participants, such as travel and other logistical costs necessary to ensure attendance and participation by children, youth, and family members.

The following are examples of potential costs to aid in evaluation that may be supported by project funds:

- Salary or contract to an evaluator(s).

- Expert consultation on evaluation design, instrumentation, data gathering, and analysis.

- Assessment instruments.

- Data collection.

- Data analysis, report writing, and report dissemination.

The following are examples of potential activities to aid in sustainability that may be supported by project funds:

- Identifying, contacting, and interacting with potential funding sources.

- Developing a capacity to write grant applications.

- Training individuals in the community to support collaboration activities.

- Covering administrative expenses associated with institutionalizing service programs in community agencies.

The following are examples of potential activities to aid in increasing competence with respect to diversity that may be supported by project funds:

- Engaging the participation of diverse ethnic/cultural/social community groups in the collaboration and collaboration activities, and in service programs, such as costs of language translation, use of interpreters, hiring of community liaison staff, and monitoring effectiveness of activities and services with different ethnic/cultural/social groups in the community.

- Increasing the competence of project staff and service program staff with respect to community diversity, such as training in diversity issues and consultation or supervision by culturally competent individuals.

APPENDIX B

SCHOOL-BASED MENTAL HEALTH PROGRAMS

The Youth Violence Prevention Cooperative Agreements grant program takes a public mental health approach to mental health promotion in communities as a preventive approach to youth violence and other youth problems. Schools or school systems can be viewed as sub-communities of residential communities. Like residential communities, schools consist of constituencies (students and teaching staff), organizations (clubs, teams, administrative units, such as the special education program), service providers (teachers, guidance counselors, school psychologists), and community leaders (principal, superintendent, lead teachers). Many of the principles of effective community approaches to youth violence prevention can be applied to the school community, including assessing youth problems, service needs, and adequacy of available services; involving provider and consumer constituencies in collaboration and program implementation; and providing services in a culturally and socially appropriate manner. Unlike residential communities, schools also have characteristics of human service systems, including an overall purpose (educational achievement), hierarchically defined roles (teaching aides, teachers, principals), and a set of formal and informal rules and regulations that govern behavior and social interactions in the system (rules on attendance, discipline, and evaluation of educational attainment). Youth violence prevention programs must also take into account the specialty service system nature of the school community.

Schools are a relatively safe social setting for youth as compared to many surrounding communities and homes. This is especially true for more serious violence--homicide, assaults with a weapon, and assault involving an injury. Nevertheless, incidents of serious violence do occur in schools, including school shootings, and there is a much higher level of "less serious" forms of violent victimization, including fights, threats, bullying, and assaults on teachers. Categorization of acts of aggression or interpersonal violence as "less serious" may come from the perspective of perpetration, but not necessarily from the perspective of the victim. Victims may experience significant detrimental effects from acts of interpersonal violence that do not involve significant physical harm. Schools can play a significant role in youth violence prevention in two ways by reducing the: (1) level of violence and victimization that occur in the school setting, and (2) propensity for violence perpetration or victimization among at-risk youth by strengthening positive personal and prosocial development through school-based programs.

The School-based Mental Health Projects in the Youth Violence Prevention Cooperative Agreements grant program are required to implement three components: (1) school-wide mental health promotion/mental health problem prevention programs, (2) identification and assessment of mental health problems, and (3) provision of or referral to mental health treatment/services. A wide variety of such programs have been developed and implemented in schools across the country. Projects are not restricted to any specific type of program or approach in any of these areas, because the scope, accessibility, and effectiveness of school-based mental health programs and models can vary with a number of factors, including characteristics of the school and the community, availability of services, administrative and staff support for specific types of programs, and resources available to support different levels of services. Rather than adopt a specific prescribed model, projects are required to

expand and increase the effectiveness of existing mental health programs in these areas, evaluate the results achieved by the school-based mental health project, and use such results in further developing the project. This appendix provides some clarification of concepts used in the requirements for School-based Mental Health projects and describes the range of variation that occurs in school-based mental health programs.

***Scope of Mental Health Programs*.** There is no general consensus on what the scope of mental health programs should be. Mental health programs may focus primarily on: (1) promoting positive mental health, or (2) addressing mental health problems. Programs that promote positive mental health attempt to support or develop personal or interpersonal competencies, capacities, and strengths that result in a competent level of personal and interpersonal functioning. Such capacities can include effective ways of coping with stress, effective personal and interpersonal problem solving, achievement of an appropriate balance of positive and negative emotional states, and competencies in interpersonal interactions and relationships. Promotion of such competencies or capacities in populations at risk for mental health problems or dysfunctional behavior may be referred to as "enhancing *resilience*."

Mental health problems may also be variously defined. Approaches to defining mental health problems include :

- Defining mental health problems in terms of syndromes of symptoms of problematic behavioral, emotional, or cognitive functioning that achieve a level of severity that affects personal functioning. Such syndromes are most often considered to be those catalogued as "mental disorders" in the Diagnostic and Statistical Manual IV of the American Psychiatric Association. These mental disorder syndromes include, for example, Major Depressive Disorder, Generalized Anxiety Disorder, and Conduct Disorder. Individuals are diagnosed as evidencing the disorder if they meet DSM IV criteria for number, severity, chronicity, and functional impairment of the symptoms defining the disorder.

- Defining mental health problems in terms of problematic behavioral, emotional, or cognitive dysfunction without regard to clustering into syndromes or having the symptoms meet diagnostic criteria for number or severity of symptoms. The severity of the mental health problem may be defined by the frequency, intensity, or pervasiveness of the dysfunction (e.g., frequency, intensity, or pervasiveness of anxiety or anger), especially with respect to usual manifestation of symptomatology in normal or clinical populations. A number of checklists are available that catalogue such symptoms (e.g., the SCL-90 or the Child Behavior Checklist). The checklists may also statistically cluster symptoms onto a set of empirically-related symptom dimensions (e.g., "Aggressive Behaviors" and "Social Problems" on the Child Behavior Checklist) and provide normative data on frequency or severity of symptoms in normal or clinical samples. This approach allows for a wider range of mental health problems than the diagnostic approach. For example, an individual might report a number of symptoms that is fewer than the number required to meet criteria for a DSM diagnosis or report symptoms that are not used to define DSM IV diagnostic categories, but are problematic for the individual or others in his/her social environment (e.g., intense loneliness or anger).

- Identifying individuals exhibiting behaviors or experiencing adverse events that often result from, or lead to, mental health problems. Indicator behavioral problems and adverse experiences are usually identified in important psychosocial or developmental areas (e.g., for adults: work, intimate relationships, family functioning; for children: attachment, school work, peer relationships). Difficulties in these areas can result from a range of biological, psychological, and psychosocial factors, including personal difficulties or inadequacies, environmental pressures, or a mismatch between personal and environmental characteristics. Individual responses to adverse events (exposure to violence, interpersonal loss or stress) can vary widely from adequate coping to chronic dysfunction. This approach usually includes screening and assessment of individuals to determine if psychological factors contribute to personal or interpersonal difficulties and what the degree of risk is for serious mental health problems.

- Defining mental health problems in terms of what the individual views as problematic or distressing in his/her psychological or psychosocial functioning (subjective distress). The intervention would attempt to relieve subjective distress, rather than focusing on problems or inadequacies of the individual as viewed by a clinician or others.

Mental health programs can differ in their focus on mental health promotion/prevention or mental health problem identification and treatment and vary in how they define mental health problems. The scope of mental health programs can depend on a number of factors, including community, individual and service provider attitudes and values, requirements for reimbursement, available resources and funding, and the experience and expertise of mental health service providers.

Scope of School-based Mental Health Programs. The service population for schools includes children and adolescents. School are the most important child service sector, because most children are enrolled in schools. As in general mental health programs, school-based mental health programs can focus on promoting positive mental health of the student population, on identifying and providing services for students with mental health problems, or on both. There is wide variation in the range of school-based mental health programs that have been implemented. These programs can vary in the scope of mental health or mental health problems addressed, types and procedures for identifying mental health problems, and models of mental health service delivery.

Programs that focus on or include promotion of positive mental health can vary in terms of capacities and strengths targeted for enhancement, depending on whether programs are targeted for the general school population or for students with risk factors; whether programs target the overall atmosphere of the school, the peer group (e.g., anti-bullying or conflict resolution programs), or individual functioning (e.g., Second Step or PATHs programs to promote social cognitive competency); and whether the programs support the natural social environment of students (e.g., playground monitoring to encourage positive play behavior) or involves active interventions (e.g., classroom-based peer interaction exercises).

Programs that focus on or include identification of and services for mental health problems can vary in the range of mental health problems addressed (e.g., addressing only mental health problems that achieve the level of diagnostic severity; or addressing behavioral or emotional dysfunction, such as disruptive behavior or depression, noticed by referral sources, (such as teachers, or addressing mental health problems self-identified by youth). Programs can vary in the type and severity of mental health problems that the school chooses to address, either with school-based services or by referrals to out-of-school service providers.

Factors affecting the scope of school mental health programs can include:

- Legislative mandates or school policy about criteria for identifying the need for mental health services, procedures for identifying mental health problems, and responsibility for students' mental health (e.g., special education identification of "seriously emotionally disturbed" students). Thus, schools, because their primary mission is educating children, might limit their interest only to mental health problems that affect school learning or performance, and not to problems that affect peer relations or family functioning.

- The values and attitudes of the school and the community, including those of key decision makers or funders, and stigmatization of mental health problems and marginalization of mental health services.

- Availability of funding for service reimbursement for different types of mental health services for children.

- Competence and experience of mental health service providers in terms of severity and types of mental health problems. For example, some types of mental health problems, such as Obsessive-Compulsive Disorder, are best treated by specialists.

- School liability issues, such as criteria used to identify students as having "serious emotional disturbance," may significantly affect resources and funding allocation for special education services, and identification of depression in adolescents has implications for liability in terms of potential suicide risk.

School mental health programs might also differ in the populations encompassed in the school-based programs. Programs might target only or primarily students, students and other staff (such as teachers), or consumers both in the school and outside of the school (e.g., students' families or youth in the community who are not in school).

Two issues that can significantly affect the effectiveness of school-based mental health program are *stigmatization* and *marginalization*.

In many communities, acknowledgement of mental health problems by individuals and efforts to seek mental health services are strongly stigmatized. This is also true in school communities, especially

among adolescents and some families of students who are having mental health problems. Such stigmatization can dramatically affect the identification of mental health problems and help-seeking in the school community. There have been three general approaches taken to reducing stigma associated with identification of mental health problems and mental health help-seeking:

- Attempting to destigmatize mental health problems by treating them as normative or as treatable illnesses. Unfortunately, destigmatization attempts are often hampered by media portrayals of extremely serious or bizarre manifestations of mental health problems as being characteristic of "mental illness" (e.g., psychotic behavior), rather than the much more common manifestations of mild and moderate mental health problems (e.g., mild to moderate depression and anxiety).

- Redefining mental health and mental health services using less stigmatizing terminology, such as labeling mental health promotion programs as promoting "positive youth development" or "well-being."

- Providing access to mental health assessment and services through another type of service that does not provide a direct indication that mental health services are being sought or provided (e.g., referral to mental health services through a general primary care adolescent health service).

In many schools, the role of positive mental health in healthy personal and interpersonal functioning and of mental health problems in personal and interpersonal difficulties of all students is not acknowledged. Mental health problems in individuals may become manifest only when they have reached a level of severity that leads to significant personal or interpersonal difficulties (e.g., school failure, dropping out of school, peer violence or suicide). In such settings, the only attention to mental health issues is to these relatively serious mental health problems, often by attempting to displace responsibility for the mental health problem outside the school setting (e.g., by referral to outside treatment providers not associated with the school, or removal of the student to special educational or residential treatment settings). No effort is made to modify the school environment to attempt to improve the mental health of students with mental health problems or of the general school population. In such cases mental health services are *marginalized* by the school. Such marginalization is often the result of a lack of understanding of the role of healthy mental development in children and adolescents and the influence of the stigma associated with mental health problems. School-based mental health programs should aim for the whole school community to embrace the concept of promotion of positive mental health, as opposed to marginalization of mental health problems in the school.

Procedures to Identify Mental Health Problems in Students. A number of different approaches to identifying mental health problems in students have been implemented. The particular approach taken may depend on the frequency and severity of mental health problems among the students that are addressed by the school-based mental health program. Among approaches taken are:

- Referrals for assessment or services by one or more sources, such as:

    - Teachers or other staff.

- Self.
- Peer.
- Parents or other family member.

Such referrals may be limited to a referral for more obvious problems (e.g., disruptive behavior) rather than more hidden or unusual mental health problems (e.g., undisclosed sexual assault). Issues of confidentiality and followup may effect the frequency of such referrals. For example, most adolescents are reluctant to identify peers who are depressed or suicidal, particularly, if follow-up for such referrals is inadequate. Similarly, teachers lose interest in mental health referrals if they are not informed of, or involved in, assessment and intervention planning and outcomes.

- Screening of the entire school population or at-risk students, often using standardized screening instruments. Screening might be for specific mental health problems (e.g., depression or suicidal ideation) or for a wide array of indicators of mental health problems. This approach can be problematic if a relatively large number of students are identified as being in need of services, but there are not enough service providers available or available, services are inadequate.

- Establishment of an identification/assessment team made up of teachers, mental health providers or consultants, student services staff, and others that meet to identify and discuss individual students who might be in need of mental health interventions and to plan assessment and intervention approaches to meet the needs of the student.

- Entering into contracts with or otherwise engaging mental health consultants (psychiatrists, clinical psychologists, clinical social workers) to consult with school staff on individual cases and/or to conduct individual assessments of students, or to refer students for assessments**.**

***Models of Service Provision in School-based Mental Health Programs*.** There are also a number of different approaches to providing mental health preventive and intervention services to either the entire school, or to students identified as having problems in need of mental health services. Some approaches to providing mental health services in schools:

- Hiring or training school staff (e.g., clinical social workers, psychologists) to conduct a range of mental health activities in the school, such as presenting psychoeducational programs, identifying and assessing mental health problems, developing intervention or referral plans, and counselling or conducting other interventions with students and/or their families. This approach might be limited by the training and qualifications of school staff, especially to address more serious mental health problems.

- Contracting with or otherwise engaging external mental health consultants (e.g., clinical psychologists, psychiatrists, clinical social workers, psychiatric nurses) to consult with instructional or student services staff on mental health issues, or on specific cases, or to conduct assessments and referrals of individual cases in need of mental health services.

- Contracting with or otherwise engaging a mental health services agency to provide an array of mental health services to the school community, either on the school site or at an outside site.

- Expanding school-based health centers to include mental health staff, or to provide referrals to linked mental health services.

Relationship to Special Education Identification and Programming. Students may be eligible for special education services through meeting the criteria for the special education category of "seriously emotionally disturbed." School systems vary widely in the percentage of students identified as "seriously emotionally disturbed," the characteristics of these students, and the type of educational programming and accommodations made for these students. Many school systems have established systems for grading the severity of the special education needs of students, which often leads to placements in regular or special classrooms, or in special facilities. The role of special education in school-based mental health programs should be given consideration, particularly since many special education students, whether or not they are identified as "seriously emotionally disturbed," have significant mental health issues.